

# **BULLETIN**



**3rd REGIONAL CONFERENCE  
TAMILNADU CHAPTER  
IUHPE - SEARB**

**PEOPLE'S INVOLVEMENT IN  
HEALTH AND DEVELOPMENT OF  
WOMEN AND CHILDREN**

**MADRAS**

**20-22 JAN 1994**

***Community Health Cell***

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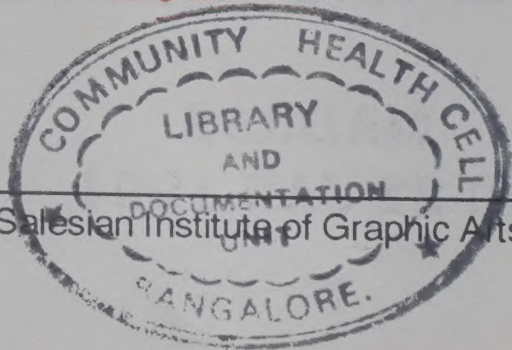


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#### Part IV



## *Section 1*

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*Concepts, Rationale, Need,  
Current status*



# 1 PEOPLE'S INVOLVEMENT FOR HEALTH AND DEVELOPMENT OF WOMEN & CHILDREN

*Dr. R.N. Gupta*

## BACKGROUND

The women and children's health and socio-economic conditions are faced with a plethora of problems. Declining sex ratio, high maternal & infant mortality, sexually transmitted diseases (STDs) - reproductive tract infections (RTIs) and human immunodeficiency virus (HIV) infections causing dreaded disease known as acquired immuno-deficiency syndrome (AIDS), lower life expectancy, anaemia and vitamin A deficiencies, low literacy, lower work participation, economic dependency, occupational exploitation, marginalization, low social status, sexual assault etc are a few examples. These problems have adversely affected the quality of life of our women and children and the national development despite Government's determined policy and all round efforts to their solutions. The Prime Minister's office has identified 27 programmes for women & children. The Government has developed a National perspective plan for women for 2000 A.D. that speaks of the development programmes including health which are in operation and which cover both women and children. The provision for them is made in our VIII Five Year plan. However, despite these national efforts, the pace of development - health and socio-economic, has not been commensurate with time, efforts and material inputs. Our programmes and strategies could make some dent in the problem solving conditions but not succeeded in eliminating these conditions-the social, environmental and ecological. Consequent to the continued population growth and disruption of ecology and environment, these conditions have made the health and development, especially of women and children, more difficult and added new dimensions. For example, the women who work for their economic independence and are empowered to avail of their rights and privileges by being educated and enlightened, generally do not succeed in detaching themselves from the household drudgery and social obligations of a daughter, mother and mother-in-law. This has caused additional burden, stress - strain and physical health problems overall discrimination. Instead of becoming independent and improv-



ing their own quality of life, they more or less support now those on whom they used to depend earlier, more so in poor rural and other underprivileged groups.

The children belonging to such groups are deprived of adequate parental love-affection, social care and safety. They are exposed to several health risks and vulnerable to anti-social acts. Many of them are deprived of the opportunities of adequate education, nutrition, healthy living conditions and recreation. Child labour, domestic chores and occupational exploitation have been socialized in a way that the legislation and other health and development measures do not fully stand to their rescue. These conditions obstruct the transparency of women and children's true perspectives on the onehand, and the Government programmes and measures initiated for them do not fully benefit them as envisaged, on the other. The women and children contain their health and socioeconomic problems to a greater extent until they take bad shapes and the sprawling poor conditions help them doing so. Who is responsible then, the power group, the people around the policy & programme implementation, the women themselves or the very strategies followed?

As we are not sure of either, we may have consensus that we all - the people, are responsible. The Government can initiate programmes, but the people have to participate in them, find out and show the way to help themselves. Several experiments have been carried out in India and other developing countries and tested this very strategy and proved the hypothesis that people can find the way to solve their problems.

The above background necessitates discussion on the subject matter from different perspectives involved and to see its relative importance through some health & development programmes.

## **NOMENCLATURE AND MEANING**

Several terms have been used interchangeably to connote similar purpose of promoting the health and development of people. The mention of the terms like, community participation, community involvement, community action, people's participation, people's involvement has been made appalingly in the literature related to health and development. The paradigms, both the community and people denote to a larger spatial group or aggregate of human beings characterizing some homogeneity, common interests and consensus. As also, the problems of such a group or people ought to be common from several counts, their interest and consensus for solving the problems would normally be identical. As such, the people themselves may solve such problems or help solve them if they participate or get involved in the problem solving strategies and action. In other words, participation, involvement, etc, as

referred to above, also signify their interchangeability for similarity in purpose, but they significantly differ in their specific meanings.

If we employ the content analysis to some of the definitions of community participation, we would get this distinction clarified. In various definitions the people's involvement is well defined through role perception viz, their involvement in decision making processes (1) their involvement in development process voluntarily and willingly, (2) contributing to development efforts sharing equitably the benefits derived therefrom, (3) involving and mobilizing more and more individuals in the planned action and utilizing the local resources, (4) what emerges out of this analysis is: "While participation implies sharing, involvement connotes a sense of belongingness". (5) As both these elements are essential for the process of development, the terminological interchangeability does not necessarily warrant to limit their scope. The use of either one has to delimit its scope of meaning for the benefit of the other term.

## ORIGIN

If we look back to the arrival of the modern system of medicine in India, we would find two problems that had evolved simultaneously in pre independent India and that perpetuated until recently. As it was a close system limited "especially to British residents in India, government employees and military personnel", (6) it created the impression of an alien system among the majority of people unable to identify it with their indigenous systems of medicine. On the other hand, it was grossly inaccessible to the common masses. This situation paved the way for reform in the organization of the system and delivery of health care in India. As a result, "some efforts were made to provide health facilities such as for control of epidemics, setting up of civil hospitals in certain urban areas and a few rural dispensaries in outlying areas. Obviously neither the health care planning nor medical education was based on the health needs of the people.(6)

As the crusade had begun, a National planning committee was constituted as early as in 1938 with pt. Jawaharlal Nehru being its chairman. He had appointed a sub-committee on National Health, chaired by col. S.S.Sokhey. The sub-committee's interim report in 1940 and the final in 1948 had highlighted the understanding of the committee for community involvement.(7) In 1946, the Health Survey and the Development Committee, known as Bhore committee had assessed the health condition in the country and suggested health development measure using the modest criteria for increasing hospital beds, providing specialized services at district hospitals and primary health care concept for rural areas. Reviewing the progress of the implementation of the



Bhore committee recommendations, the Mudaliar committee found in 1961 that the Bhore Committee targets were not achieved even after a decade and a half. And thus recommended speedy implementation of the recommendation and suggested some additional measures. Prior to this, the Community Development Programme launched in 1952 had also laid considerable emphasis on the health and women development in India. The launching of this programme had “ushered an era of development with the participation of the people:.”(8) The chadha committee realizing the health needs of people recommended in 1965 the training of the rural health workers to make the multi-purpose health workers which was reiterated in 1973 by Kartar Singh Committee. The development in the field became more focussed in 1975 when the Srivastava Committee recommended the use of rural manpower resources for health care delivery to the masses on the lines of the voluntary agencies. In 1976, the ICMR sponsored a 3 centre study of Feasibility and Effectiveness of Involvement of Rural School Teachers in Primary Health Care system. “In this context the utilization of the services of educated non-medical workers available in the villages like school teachers, postal staff, gramsewaks etc, was commended”.(9) It may be mentioned here that the innovative thinking and development that were taking place in the neighbouring country china could have also influenced our national thinking and efforts. John Grant’s proposition of the use of “lay people” in health care that he had advocated in 1939 and later, the use of barefoot doctors appear close to the spirit of col. Sokhey committee’s recommendations in 1940 and Srivastava Committee’s recommendations in 1975. It was J.P.Naik, a member of Srivastava Committee, whose “persistent efforts to promote community self-reliance in health matters received powerful support when, in the wake of 1975-77, the new government adopted the policy of entrusting the people’s health to the people’s hands through training community health workers chosen by the people themselves”. (10) Further, the ICSSR and ICMR made a joint panel that constituted 4 subgroups to study different aspects of health in India. The study of community participation in health was assigned to one of the groups. This panel has been revived this year. Keeping pace with the development, the ICMR-ICSSR had organized jointly a symposium on Alternative Approaches to health care at the National Institute of Nutrition, Hyderabad from 27th to 30th October 1976, a National Conference on Evaluation of Primary Health care programme at ICMR, New Delhi from 21st to 23rd April 1980, and a National Workshop on Appropriate Technology for Primary Health care at ICMR, New Delhi from 23rd to 26th April, 1981. Community participation for Community Health was an important part of the deliberations of these national level scientific fora. “The concept of primary health care through non-medical village workers was later reinforced by the WHO at the Alma Ata Conference held in 1978”.(9)



## RATIONALE

Health is an essential input to human resource development culminating into behavioural transformation that influences the quality of life and status of society. Health, more appropriately, public health was elaborately defined in 1920 by C.E.A. Winslow as "the science and art of preventing disease, prolonging life and promoting health and efficiency through organized community efforts for sanitation of the environment, the control of communicable infections, the education of individual in personal hygiene, the organization of medical and nursing services for the early diagnosis and preventive treatment of disease, and the development of the social machinery to ensure everyone a standard of living adequate for the maintenance of health, so organizing these benefits to enable citizen to realize his birth-right of health and longevity".(11) Acknowledging the merit of WINSLOW'S contention, George Rosen viewed public health in 1963, as a significant functional system of the community, that may be understood as community action in the interest of health.(11) John B. Grant described community health care a less narrow term than public health. "The personal services, whose aim is to protect, promote, and restore the health of individuals, are part of a spectrum which was environmental services at one end and educational services at the other. Especially when resources are limited, the initiative and capabilities of the people must be enlisted for self-help; but even in advanced countries the quality of medical care depends on the public's using the technical services wisely. A backward community must be shown its needs; but, unless there are also ways of meeting them, the results will be frustration and social instability.(12)

In Indian context, it has been realized, time and again, that people's involvement in health and development is indispensable. It refers to the process that empowers people to actively participate in decision making, planning and action in such programmes. It envisages to organize and or energize viable receiving mechanism at the grassroot level for Government programmes and provisions and adds to their sustainability by mobilizing and utilizing the community resources for drawing maximum benefits. Thus, the people's involvement is being hailed all over the world for the promotion of health and development in developing countries. Late Prime Minister, Mrs. Indira Gandhi had rightly observed, we have capable well trained doctors who go out to treat diseases. But there isn't that consciousness of seeing whether the neighbourhood in which they live themselves is conducive to healthy living, or they have created that feeling in the people's movement which brings into focus the things which some of us take for granted but which unfortunately the large majority of our people, even if they are affluent, even if they have all the opportunities, do not always take care about."(13)

Thus, in order to derive benefits of medical discoveries and available knowledge and facilities for preventive and promotive aspects of health, and socio-economic benefits of development programmes and provisions, the people's involvement appears to serve if not as a panacea, certainly as a viable strategy for rural health care.

## **NEEDS**

The needs of people's involvement for health and development have been reflected by different persons while discussing the elements (4,14) and conditions (15) necessary for involving them or evoking their participation for solving their health and socio-economic problems. The needs that appear essentially to people's involvement may be discussed as under.

### **1. Leadership:**

If it does not already exist, an effective and non-controversial person is to be identified, sensitized with problem and his/her leadership skills viewed and updated, if required, with respect to the problem and the target programme.

### **2. Coordination:**

The presence of coordinating aptitude among the people targeted for their involvement in a development programme is a must. Wherever it is absent or weak, it needs to be built up through suitable information, education and counselling. Further, there is a need to have a coordination committee for successful involvement of people in community action. The ICMR has ventured it at state and district levels in its MCH and contraceptive trial studies.

### **3. Receiving mechanism:**

There needs to be an institution, a group or a mechanism of implementing and sustaining the strategy of involving the people and implementing the programme aimed at solving their problem of concern. The strategy or programme may be suggested or brought by some other group to which the community might have already agreed and got involved in the operational steps etc. However, the very institution or group that will receive it in right spirit and operationalize it, will be a different but necessarily community's own like, a select group of women or men, the panchayat, school, cooperative society, Mahila Mandal, Youth Club and samiti etc. are such popularly known community institutions. The ICMR in its multi-centre study of Young Women's Health & Development programme has successfully tried this mechanism by establishing the Yuvati Vikas Kendras at village level.

#### **4. Priority of problem:**

The problem that ought to be solved through people's involvement should occupy a priority position in the community's need hierarchy. It should attract majority attention and arouse their concern. If the disadvantages and threats caused or likely to occur due to the problem and the mode in which they are affecting or would affect the health and socio-economic conditions of women and children are perceived by the people, as serious, the problem would occupy the priority position in their need hierarchy.

#### **5. Consensus programme:**

The community including its leaders, elites and the development agency need to have consensus on a feasible strategy or programme. They should be able to see the possible advantages through that foreseeable programme.

#### **6. Role perception:**

The people should perceive their roles and responsibilities with full understanding of the pros and cons of their getting involved in the community action for health and development for women and children on the one hand, and whether they would be able to cope with the demand of the programme, on the other. This is a kind of self-appraisal. The sponsors or external initiators of the programme also need to relate their perception of the people's roles and responsibilities with their potentials.

#### **7. Skills & resources:**

A feel of the technical skills and resources available with community and nature & extent to which additional minimum external support would be required from the sponsors is also a pre-requisite of the people's involvement.

#### **8. Skill building:**

People should be willing to acquire or update their skills prior to getting involved in the programme aimed at solving their problem.

#### **9. Self-help:**

The spirit of self-help should prevail on the people while taking their role in their health and development measures. If the people realize their potentials and worth, they would have intension of helping themselves as against depending on other's help from outside the community.

#### **10. Mobilization of measures:**

The community resources should be mobilized, energized and maximally utilized. The dependence on the external agency resources should be limited and gradually minimized and finally withdrawn.



### **11. Judicious use of external resources:**

The needs of technical and material inputs in people's health and development programmes may not be denied. But there should be judicious use of such resources. Some times massive resources are made available but another time the resource scarcity is felt. In both the situations, the spirit of people's involvement is vitiated and the potential of own resources and their growth are jeopardized.

### **12. Preservation of values:**

There is a need in the endeavour of people's involvement that the established life style and community value should be preserved. Any programme or strategy should be evolved in such a way, that fits well in the cultural milieu of the community. Otherwise, resentment would grow and the whole development endeavour meet a setback.

### **13. Voluntarism:**

The people should exercise their voluntarism to realize the problem that pertains to the community and fully involve themselves in the programme or measures aimed at solving that problem. They should participate in the decision making, planning, implementation, monitoring, evaluation and overall management of the programme. This will inculcate in them a sense of responsibility and belongingness without which their involvement will not be fully ushered.

### **14. Appraisal of efforts:**

It is very important to appreciate the efforts of the people involved in the community action. This will encourage the people to keep up their interest. The interim gains of their efforts need to be highlighted and commended. This opportunity should also be availed of, for making them to understand the bottlenecks and rectify them.

### **15. Sustainability:**

The programme initiated or strategy followed with the people's involvement needs to be sustained. This would be possible if it is scheduled at the planning stage and made a part of their responsibility. It is a kind of self imposed target that after a specific period they would be on their own and continue the programme. In absence of this provision, the programme and people's involvement would not be effective for too long. The gradual withdrawal of external involvement of agencies and officials should be supplemented by community's own resources for achieving the sustainability.

## APPROACHES

There are several approaches followed for eliciting people's involvement in health and development. Some of them are as mentioned below:

1. Five Year plan approach.
2. Community Development programme approach.
3. Primary Health Care approach
4. Vertical programme approach
5. Integrated programme approach
6. Inter-Sectoral Link approach
7. IEC approach
8. Community Organization approach
9. Clinic, Camp and Mela approaches
10. Bottom-up approach
11. Role Model approach

Rifkin 16 has discussed three approaches viz. Medical approach, Health service approach, Community Development approach which also find their reflection in the above approaches.

### **1. Five Year plan approach:**

The sixth plan had identified the problems of women, especially poor rural women as (i) marginality of attention and services to them in rural and agricultural development; (ii) special constraints that obstruct their access, to available assistance and services such as lack of training to develop their awareness and skills; lack of information and lack of bargaining power; (iii) low productivity and narrow occupational choices; (iv) low level of participation in decision making; (v) inadequate finance and expert guidance for promoting socio-economic activity of rural women and their participation; (vi) inadequate monitoring of women's participation in different sectors; (vii) wage discrimination; (viii) inadequate application of science and technology to remove drudgery; and (ix) low health and nutrition status.”(8) In order to solve these problems and improve the status of women, the 6th plan recommended “to secure for them a fair share of employment opportunities, to earmark a percentage of allocation for women, and to fix for them a quota in all the poverty alleviation programmes. The 7th plan reiterated the strategies suggested in the 6th plan with a sharper focus on the increased coverage of women in various rural development programmes”.(8)

### **2. Community Development approach:**

The Community Development programme approach (1952) led the establishment of the National Extension Service Blocks in rural areas for



overall development of people. Health and women's development were important service components. The allocations for the extension services tapered during the 3rd Five Year plan. This led farmer oriented schemes like, food for work, Rural Employment and other programmes. The land reform measures were also introduced. These programmes were not exclusively male oriented, the benefits of these went to women and children also.

### **3. Primary Health care approach:**

Our National Health policy (1983) envisages its commitment to attain the Health for all by 2000 A.D. following the Primary Health Care approach through Minimum Needs programme that aims at strengthening the Primary Health Centres, Sub-centres and Community Health Centres.

Alike the preceding 6th and 7th Five Year Plans, the 8th Five Year plan also lays greater emphasis on the health and development of people of India that comprises over 40 percent women and girls. Out of 6 objectives of the 8th Five Year plan, the first 4 are devoted indirectly or directly to people's health and development. The plan suggests further, "people's initiative and participation should be made a key element in the process of development.(17) One of the thrust areas of the plan in "to empower women by raising their status and bringing them into the mainstream of national development not as more beneficiaries but as contributors and partners along with men."(18)

### **4. Vertical programme approach:**

The primary health care approach has been followed and strengthened for the delivery of health care services in order to achieve the goal of Health for All by 2000 A.D. as per our National Health Policy. But paradoxically, most of our national programme for control of communicable and non-communicable diseases are being carried out vertically. However, so far as the people's involvement is concerned, the malaria eradication programme (1952) - modified plan (1976), tuberculosis control programme (1962), leprosy control programme (1976) etc, have witnessed the advantage of people's involvement. The ICMR's Vector Control Research Centre, Pondicherry and Malaria Research Centre, New Delhi have tried community participation for accomplishing different activities that help prevent malaria. In a pilot project of Karnataka State Tuberculosis Association (1962), the community participation was experimented for preventing the irregularity in the treatment of tuberculosis. The community volunteers made over 2000 home visits and helped in case holding.

Way back in 1951, the Gandhi Memorial Trust, Sewagram experimented with community participation and later a number of other voluntary participa-

tion in the control of leprosy. Similarly, the voluntary organizations have succeeded in mobilizing and utilizing the community in Universal Immunization programme, control of diarrhoeal disease, blindness control, anaemia prophylaxis and such other programmes.

### **5. Integrated Development programme approach:**

National Family Planning and Maternal & Child Health programmes are integrated one. In both these programmes, people's involvement has always been solicited, though not succeeded fully. There are socio-economic development programmes and women's status raising programmes with focus on literacy and income generation e.g., Working Women's Forum, Madras; KEM Hospital, Pune's Vadu Budruk Integrated Rural Health Project; Jamkhed Comprehensive Rural Health project; UPASI Integrated Community Health Project; Mallur Health & Family Planning Project; Athur Family Planning Project; Naujhil Integrated Community Health Project, SARTHI and CHETNA programmes, ICDS etc. Which have identified, trained and involved people - men and women, for solving their health and socio-economic problems and demonstrated success.

In an ICMR-WHO Collaborative Study, the rural practitioners of Indian System of Medicine were trained and involved in family planning programme for the delivery of services to their male and female clients and other couples in the village where they practised. The experiment showed not only the feasibility of involving them in the family planning programme but also the improvement in the utilization of the services.

The Banwasi Sewa Ashram followed the integrated development programme approach in their Agrindus Family Welfare project in Mirzapur. "The project aimed at the all round development and awareness building of the families and of the community and not mere limitation of the number of children in a family. This was achieved by integration of the health and family planning activity with the other activities of the Banwasi Sewa Ashram for the development of agriculture, animal husbandry, village indsutries, education and organization of communities working on the basis of concensus for self-sufficiency and self-reliance (or for Gramswarajya). For developing these various programmes whole community was treated as one unit."(19)

### **6. Inter-Sectoral Link approach:**

The women's employment leading to economic independence has been recognized as one major factor to their development and social status. However, without literacy and occupational skills, they may not succeed. This realization led the initiation of the Integrated Rural Development programme (IRDP) in



1978-79. Under this programme, the Training of Rural Youth in Self Employment (TRYSEM) and Development of Women and Children in Rural areas (DWCRA) and many other such programmes like literally Rural Landless Employment Gauranty, Technology Mission on Drinking Water, Indira Awas Yojna etc, have been launched in the country.

These programmes are monitored by the Deptt. of Women & Child Development under the Ministry of Human Resource Development, though some of them belong to other Ministries. The coordination of different deptts. and Ministries is sought and linkage maintained for successful implementation of the programme and benefits to the women and children by the above department.

### **7. IEC approach:**

The 8th Five Year plan has identified the community participation as one of the weakest links in health programmes. As such, it envisages that the Information, Education and Communication (IEC) should be given special attention in each programme so as to enlist the community participation.

The IEC approach, especially in family welfare programme context, has received much attention in recent years. Though, as a concept it appeared more synchronized and organized now, as an approach it is being followed since long. Almost in all health and development programmes, in one way or the other, the IEC element is present. Without proper IEC inputs in a programme, neither the people's involvement may be sought nor success achieved.

What information and education may be required for the people or volunteers and the rest members of the community for a particular programme and what communication contents, material, skills and channels etc. required, need considerable planning and experimentation before their fulfledge application for sensitizing, organizing and involving the people in the programme? Community organization is a highly potent tool for public health and social engineering. Its proper understanding and training make easy the dealing with women and children's problems and seeking people's cooperation.

Its role in controlling the blindness, leprosy, tuberculosis, malaria, fertility, school health problems and infectious diseases in children, STDs and now AIDS, and environmental pollution, has been hailed. The programmes and research experiments cited above under different approaches have had, one way or the other, this approach followed mainly with education and training components for organizing the community and involving the people.

Besides generating required information in a planned manner without using cumbersome tools, it facilitates the flow of information between the



agency and community involved in the action. Thus, a two-way communication using effective media, instructions and methods is maintained in order to achieve the goal. Whereas the approach provides feedback to the concerned people and helps in assessing the strength and weaknesses of the endeavour, the feedforward is an added advantage accruing out of it. The approach reinforces the motivation and involvement of people for timely measures deemed necessary for the success of the programme and their maximum benefits.

The approach is capable of placing people's health in people's hands and enabling them to solve their socio-economic problems themselves.

### **8. Community Organization approach:**

The success of women and children's health and development related programmes depends largely on the community, its organizational strength, people and institutions. While discussing the community organization approach, a very pertinent question that arises is: how the community is better organized in order to elicit people's consensus and involvement in the programme aimed at their benefits. The community organization may be done effectively by sensitizing the people about the "problem" that is to be solved with their involvement. They should be educated about the disadvantages and losses caused and likely to be caused by the problem. Also, they need to be told about the immediate and long term benefits as well as their roles, capacity, contribution in solving the problem and the support that may be made available in addition to the community's own limited resources. This process motivates them for organizing themselves individually and in groups and institutions like, Mahila Manadals, Youth Clubs, Samitis, Cooperatives etc. and mobilizing the already existing institutions like, Gram Panchayat, Community Development Block, educational and philanthropic institutions and trust. Wherever, the community has been organized and people involved in right spirit by the programme sponsors, the programme have witnessed success.

"There have been various experiences and experiments inside and outside the community which have shown the use of local persons from the rural community acting as "change agents" and "links" between the community and the health centre and proved effective enough in changing the behaviour of the people and in making available to them a kind of readily accessible service for each and every family. Regardless of what designation may be given to that person, an immediate alternative approach to widen the health care delivery system and its coverage is to identify and select in consultation with the rural people a "front line" community health worker from the community itself. Along with this, it is absolutely necessary to form village health committees."(20)

The Ramalingaswami Committee (1980) felt essential and recommended one representative from each group of 20 families in order to provide a voluntary base for health in the community. Similarly, the Kripa Narayan Committee (1981) realized the importance of people's involvement and recommended the identification of matured and socially accepted people in each village and designated as "Swasthya Pancha". In the same spirit, the formation of Arogya Samiti and involvement of Village Panchayats have been recommended.

Vasudeva reports, "the Panchayat, its members and the Sarpanch have been found to be reporting epidemics, asking for refuse dumps, removal of manure pits, demanding that the health agency carry out dog - destruction, pest control, DDT sprays. Cooperative activities may be the provision of accommodation for sub-centres and health workers, or payment of rent for it. The panchayat often does agree to some Do's and Don'ts spelled out by health authorities".(21)

There are some other examples from health services and research programmes which have shown the benefits of involving people from the community for their own health and development e.g., the Trained Birth Attendants (TBAs), Community Health Volunteers or Guides, Anganwadi Workers, School teachers, Rural Practitioners of Indian Systems of Medicine, Tibetan Delek Hospital Dharmshala's Community Health project etc. The efforts of Self-Employed Women's Association in organizing the street vendors of Ahmedabad and Lijjat papad organization (22) are commendable.

The approach of organizing and involving people in health and development schemes got a good thrust during the last decade. It is evident from the above examples that the women's participation has proved significant in both the health and development spheres. Thus, the preferential involvement of women has been considered important. The ICMR-ICSSR Joint Panel report on Health For All: An Alternative Strategy suggests "if only one community health volunteer is to be placed in a village then the volunteer should be a woman rather than a man since most of the important village level health concern women". (23)

## **9. Clinic, Camp and Mela approaches:**

The village health clinics, mobile camps and melas have been successfully experimented in different programmes, especially family planning programme. These approaches have proved to be good means of attracting, communicating with and involving the people in the programme for achieving better performance but not for a too long duration. Initially, the family planning programme followed the clinic approach. The extension and camp approaches were adopted later, especially for sterilization and insertion of intra-uterine



device (IUD). Massive vasectomy camps in Kerala, Gujarat, U.P. and Bihar had witnessed the success of this approach and people's response to family planning programme in the 60s and 70s, with exception to some excesses in the later period. But the people's overwhelming response to the National Programme and involvement, vis-a-vis intersectoral coordination in support to the approach could not be sustained due to management and administrative reasons. The most deterrent reason was the excesses committed during the Emergency of 1975-77, (10), followed by change of the then Government.

The mobile camps organized by several non-government organization (NGOs) in different parts of the country have also succeeded in enlisting people's involvement. Similarly, in 80s, there were noon melas organized in M.P. for promoting family planning in the state. The participation of women in sterilization camps is a testimony of community's involvement. Though incentives and other factors play vital role in the motivation and involvement of couples, these approaches have showed the way for achieving success of the programme. There are instance when the out door patient clinic approach in leprosy (24) and service outreach clinic approach in health care were followed and people's involvement accomplished.

### **10. Bottom-up approach:**

The bottom-up approach lays emphasis on the importance of development planning through women. The women should be involved at the grassroot level for effecting necessary change.

### **11. Role Model approach:**

The role model (25) relates to the awareness of women and making them able to realize their self-esteem, worth and develop confidence. This in turn facilitates the aspirations of the women and thereby helps in decision making process and participation in the programme of benefits to them and the children.

Though for the discussion and clear understanding of people's involvement for health and development of women and children different approaches are dealt separately, the anomaly with them is such that some of them are not mutually exclusive.

## **BARRIERS**

The people's involvement for health and development of women and children is not free from impediments, especially when both these sections of the population are low literate and poverty ridden. There are several such factors inherent in the social, political, government and non-government systems



which appear as barriers to the success of the process of people's involvement. Some of those barriers identified are as under.

1. Low literacy.
2. Poor accessibility to information.
3. Poverty.
4. Low status of women.
5. Community faction/stratification.
6. Weak leadership.
7. Interference of elites.
8. Centralization.
9. Confounding integrity.
10. Poor commitment.
11. Unforeseen events.

### **1. Low literacy:**

The low level of literacy, especially among women and children does not help much in the efforts of removing their ignorance and conservatism. The change in their attitude and behaviour becomes difficult and takes long time. It impedes the process of people's involvement. Because of their tendency of being in the state of fixed ideas and following conservative approach, people do not perceive easily the benefits of a particular involvement. In such a situation of ignorance and conservatism due to low level of literacy, the women and children fail to find their wrong attitudes and beliefs as deterrent to their health and development and silently negate the process that aims at their benefits. Infact, they fail to focus their needs and problems. Thus, the process of people's involvement does not get support and further momentum.

### **2. Poor accessibility to information:**

The women and children's poor accessibility to information is another factor that keeps them away from important instructions and educative measures about their own health and development. This keeps them away from the main stream. This factor gives indirectly rise to their ignorance on the one hand, and shuns their need arousal and enabling processes on the other. As a result, neither they manifest their aspirations and get motivated to participate in the process of solving their problems nor they facilitate others' participation in such process.

Though the access to information is a human right, the impediment in this area keeps the communication gap unbridged and leads to several problems.

### **3. Poverty:**

About 30 per cent people in the urban areas and 33 per cent in rural areas were found to be below the poverty line during 1987-88 (estimated following the physical survival approach, i.e. per capita per day calorie intake of 2100 in urban and 2400 in rural areas or its conversion into monthly per capita expenditure, i.e. Rs. 101.80 for rural areas and Rs.117.50 for urban areas at 1983-84 prices). (26) The people with sustained poverty for a long period may be seen with different attitude, behaviour and overall life style representing the culture of poverty. This fact of life of the people does not prove fully conducive for the action like health and development. One study observed, "They are too poor to concern themselves in the sanitation or mosquito nuisance. Health can not be viewed in isolation and health care, including vector control must be delivered in a package programme along with other benefits of a socio-economic nature". (27) Thus, the people's involvements may not be taken for granted as a successful approach in a situation where the poverty has caused pessimism, reluctance to solutions to their own problems and hampered the initiatives of the people.

### **4. Low status of women:**

Low status of women that inhibits them from realizing their self-esteem and worth does not prevent them for taking independent decisions and availing of their rights, keeps them economically dependent and vulnerable to several problems, is another factor that weakens people's involvement in the activities that may benefit them.

If the women achieve due status in the society, many of their and children's problems may be solved through their involvement. Where the woman has privilege, achieved education, status and is involved in the programme of development, she has proved her worth and also the success of the approach of people's involvement. Some of the programmes like, ICES, Self-Employed Women's Association, Working Women's Forum, are such existing examples. .

### **5. Community faction/stratification:**

In a community where contentious or selfish groups emerge due to political, economic or social reasons or where the caste, religion or class stratification becomes too sharp, the community consensus becomes difficult. As such, organizing the community for a common goal and eliciting people's participation and involvement become too difficult. Any programme of health and development for women and children contingent on people's involvement, may not succeed in such a situation.

## **6. Weak leadership:**

A weak leadership will not be able to organize and mobilize the community for people's involvement in a programme aimed at women and children's health and development. A weak leadership vulnerable to pressure and influence of vested interests may not effectively lead the movement of self-help. A programme of women and children's benefits needs, besides other conditions, a stable and active leader, preferably a woman. If the leader possesses the attributes of commitment and dedication to the cause of the people like charismatic or missionary zeal besides the high degree of social acceptability, the leadership will be strong and stable and give direction to people for properly channelizing their physical and material resources for their own benefits and thus set a good example of people's involvement. Other wise, the leadership will prove to be a barrier to the approach of people's involvement.

## **7. Interference of elites:**

The interference of political and other elites in programme of development jeopardizes its success. It is good to take good wishes of such people and seek their support as well but their interests and involvement should be checked from the beginning of such programme. Any direction from them should not be encouraged. This may be possible only when the programme is kept neutral and the community is heavily involved and relied upon since the beginning. Otherwise, the involvement of right thinking people, people who wish to solve their problems by themselves will cease and they would not extend their support and the programme will meet a setback.

## **8. Centralization:**

Centralized planning, action and holding of resources including finances etc. will definitely hamper the success of the approach of people's involvement. This has been evident in a number of public health and development programmes being run by NGOs using people's involvement approach, who have failed to see the success of their models in the situations other than their own. Many NGO projects have demonstrated the success in their own areas but that has literally not been replicable elsewhere. This has been because of the control of resources, deployment of their large manpower and use of good infrastructure and centralization of all affairs. As such, from the initial stage of a programme of people's involvement, decentralization should be fully adhered to and the programme given in the hands of the people.

## **9. Confounding integrity:**

There is a barrier like confounding integrity of the sponsors. If their implicit objectives and motives are not clear to the people, the people may cease



to cooperate with the sponsors. At the time when they develop suspicion or doubt about their integrity, a well planned programme progressing even in the hands of people may collapse.

#### **10. Poor commitment:**

If the commitment and support - technical and material is not met regularly or as per the planned schedule, it may pose barrier to the approach. Also, if the attitude and support of the sponsors - bureaucrats or NGOs are witnessed by the people as withdrawn, the whole approach to the programme of development will collapse.

#### **11. Unforeseen events:**

There may be some unforeseen social events or natural calamities causing barrier to the people's involvement. These may be some shock due to death or criminal assault, dacoity, mass exodus, epidemics, draught, flood, fire, earthquake etc.

### **FACILITATORS**

Women and children's health and development problems may not be viewed in isolation of their social aetiology. Most of their health and socio-economic problems evolve out of their social conditions. Similarly, the viable and lasting solutions may also be found out of the same social conditions. This contention focuses on people's own initiatives and measures to solve their problems. There are other sources also that facilitate people's involvement. These are;

1. Community itself
2. Local elites
3. NGOs with effective IEC
4. Govt. development institutions

#### **1. Community itself:**

A cohesive community elicits easily the consensus of people for solving their problems through their involvement with little external support. Such a community finds its people's aspirations and motivation raised that promise commitment and devotion to the cause and they exercise voluntarism to participate and get involved in the action. The community tries to arrange, energize and utilize its own local resources. It heavily depends on its own resources. These attributes and advantages of the community facilitate the task of people's involvement in their development and health related programmes.

## **2. Local elites:**

The role of local elites in facilitating people's involvement in the programme of their own benefits is of prime importance. A local leader - social, religious, a person of high repute and credibility, or a philanthropist is always known, respected and trusted. The support or direction from such a person always facilitates the people's involvement in the action of their own interest. Many programmes in health, social reform, and socio-economic development of women and children have witnessed the success because of such people.

## **3. NGOs with effective IEC:**

The main tool of success of NGOs in development programmes has been their effective information, education and communication approaches. They first study and appreciate the people's problems. Secondly, they sensitize, motivate and involve the people in action. With due inputs-technical as well as material support, they create conditions that people start mobilizing and utilizing their own resources. Thus, the NGOs with their effective IEC facilitate the people's involvement in achieving their goal by themselves.

## **4. Govt. development institutions:**

It is not that the community and or NGOs may alone solve the problems of people. The Govt. support, both technical & financial, development plans, and programmes do have crucial role in facilitating people's involvement. There are several development agencies and deptts. that sponsor and run development schemes through their own institutions, through NGOs and directly under respective ministries.

It emerges out of the preceding discussions that for people's involvement in health and development of women and children, strong will of the people is necessary. They should be willing to solve their problems themselves with whatever little external Govt. or NGO support is made available to them, but without depending on the sponsors. This approach to the problem will ensure sustained involvement of people and success in their mission.

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An essential component of primary health care is the idea of community participation and self-reliance. In the words of Dr. Mahler,

“The primary care approach represents a reformulation of some of the most basic tenets of public health. It is a return to the idea that health is a vital element in the growth and development of individuals and communities, that it is a basic human right, and that its promotion goes far beyond the provision of medical care. The approach aims at promoting community and individual self-reliance in health ... and it implies that people should act to improve their own health rather than rely on others to do it for them.”

Any serious problem has to be tackled via the greater participation of the people involved — especially young people. We need Safe Motherhood to be a question not only of today's mother, but of tomorrow's as well.

—*Mohammad Fazlul Haque*  
*Bangladesh National Youth Organisation*

## 2 PLACING HEALTH AND DEVELOPMENT PROGRAMMES FOR WOMEN AND CHILDREN IN PEOPLE'S HANDS : AN OVERVIEW AND PERSPECTIVE.

*Dr.K. Venkateswara Rao, MBBS., DCH. Ph.D., FIPHA*

The health problems of women and children are many and varied. Suffice it to say for purposes of this paper that the problems of women and children are natural, physical, mental, social, cultural and economic in origin. In several instances, no one single factor contributes to the ill-health of the women but a complex interaction of several of these which play a key role in determining the manifestations.

Developing countries such as ours stand at one end of the spectrum of high mortality, poverty, early marriage, early mating, frequent child birth, infection, communicable diseases, nutritional problems and problems of the household and environment. The pattern of ill-health among mothers is due to 'maternal depletion' as a result of combination and permutation of these factors. Coupled with these are protein denying food prejudices, uninterrupted overwork leading to premature ageing. Most of these problems arise from controllable as well as uncontrollable causes. Macro and Micro level determinants, society and family based situations, representing a complex canvas in the background of poverty, illiteracy and uneven growth of the economy.

Epidemiologically speaking, the lower body weight found in malnourished female adults is significantly associated with mortality and morbidity risks or pregnancy for both mother and child (Srikantia, 1989). The determinants of gender based differentials in nutrition appear to be complex, involving cultural, social and economic factors (Chatterjee 1988).

According to Ramachandran (1989) anaemia combined with chronic undernutrition and pregnancy contributes heavily to both maternal and infant mortality. Recent research has suggested that adult and adolescent women may also be carrying an immense burden of unrecognised reproduction related morbidity. A study in Maharashtra reported that 92.2 per cent of women surveyed had one or more gynaecological or sexual diseases, with an average of 3.6 conditions per woman. (Bang et al 1989).

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Chronic nutritional and health deficiencies and acute morbidities in adult women combined with high fertility and limited access to health care and acceptable fertility control methods are responsible for India's high maternal mortality rate. A widely quoted study in Andhra Pradesh reported more than 800 maternal deaths for every 100,000 births (Bhatia, 1988) whereas the national figures are 460 maternal deaths for 100,000 births. According to Chatterjee (1988) the high fertility rates and high mortality rate indicate that the life time mortality risk of reproduction to an average Indian Women is about 300 times greater than that of many high income countries.

Large scale multi-state surveys of nutritional status and food intakes have repeatedly reported high levels of serious undernutrition amongst children in India, with 40 to 50 per cent in the lowest two grades according to weight for age. In the Pre-school and school going age children of the lowest groups have a caloric intake of 62 to 75% of the recommended levels.

There is still high levels of the infant mortality. Diarrhoeal diseases remain a major cause of morbidity and mortality in infants and young children.

## **PLANNING HEALTH AND DEVELOPMENT PROGRAMMES FOR WOMEN AND CHILDREN**

From time immemorial, several countries in the world have been making efforts to make health services more meaningful and comprehensive. History is agog with examples, success stories, micro experiments and charismatic leaderships leading on to focal and local efforts.

India also did not lag behind in making innovative experiments in the field of health care. Not surprisingly, major efforts have originated from voluntary action with the Government chipping in by broad basing success stories.

In a milieu of poverty, economic deprivation, illiteracy, ignorance, culture bound traditions, superstitious beliefs and practices people innovated within their capacity and means to search for remedies that can cure day to day health problems. Obviously precious little could be done in the matter of tackling the acute problems and serious infections. Even the matter of financing the health care was left mainly to the families themselves with the State coming in for the maintenance of distantly located, sparsely distributed curative centres which were taking greater care of the elite in the society.

The first authentic effort at health planning was made by Sir Joseph Bhore and his team who surveyed the health scenario in the country in the year 1946. Roughly in the middle of the current century, when elsewhere in the developed world people have conquered communicable diseases even without the help of

anti-microbial agents which were not discovered, people in India had to walk long distances to get rudimentary medical care which was curative oriented. From then on efforts were continued at developing the health infrastructure and maximising its impact by the appointments of several committees, such as Mudaliar Committee, Col. Raina Committee, Chadha Committee, the two Mukherjee Committees, the Jungalwala Committee, the Kartar Singh Committee, Shrivastav Committee etc. Simultaneous with the appointment of these committees and perusal of their recommendations, due to pressures of diseases of public health importance such as malaria, leprosy, filariasis, small-pox, cholera, trachoma and STD, several individual diseases control programmes were established in the country with uni-purpose workers. Considerable international pressures for controlling/eradicating the diseases also took away the essence of primary health care from the basic health services and this resulted in a fragmented, dilapidated infrastructure with grossly inadequate resources, men, material and money including the much needed management.

Several success stories in the field of health care, pouring in from several developing countries, have prompted the international agencies such as WHO, UNICEF etc., to focus attention on the need for broad-basing the primary health care strategies with the aim of providing 'Health For All' by the turn of the century. The Alma Ata declaration has clearly demonstrated the need for political will and judicious deployment of resources for better and efficient financing of the health care systems. The ICMR/ICSSR Committee and the working group of the ministry of Health reiterated India's commitment to this goal and suggested plans of action.

The National Health Policy (1982) states "the existing approaches instead of improving awareness and building up of self reliance has tended to enhance dependency and weaken the community's capacity to cope with its problems. The prevailing policies in regard to education and training of medical and health personnel at various levels has resulted in the development of a cultural gap between the people and providing care. The various health programmes have by and large failed to involve individuals and families in establishing a self reliant community. Also over the years the planning process has become largely oblivious of the fact that the ultimate goal of achieving a satisfactory health status for all our people cannot be achieved without involving the community in the identification of their health needs and priorities as well as in the implementation and management of various health and related programmes.

As regards the primary health care, the national health policy states "To be effective, the establishment of the primary health care approach would involve large scale transfer of knowledge, simple skill and technologies to



health volunteers, selected by the communities and enjoying their confidence. The functioning of the front line workers selected by the community would require to be related to definite action plans for the translation of medical and health knowledge into practical action in involving the use of simple and inexpensive interventions which can be readily implemented by persons who have undergone short periods of training. The quality of training of health guides would be of crucial importance to the success of this approach.”

“The success of decentralised primary health care system would depend vitally on the organised building up of individual self reliance and effective community participation, on the provisions of organised building up of individual self reliance and effective community participation, on the provision of organised back up support of the secondary and tertiary levels of healthcare services, providing adequate logistical and technical assistance.”

The twenty point programmes of the successive Prime Ministers and the national health policy laid emphasis on taking care of vulnerable sections of population, notably mothers in the reproductive age agroup. The seventh five-year plan gave a 12 point charter for the improvement of health of mothers. The eighth five-year plan also has proceeded on similar lines.

Community participation is seen as the key to primary health care. This has obtained a prominent place in health care strategies in many countries and programmes for a number of reasons:

- a) increasing evidence is being provided to show that high medical technologies are less important for health improvements in large communities than what people do and can do for themselves.
- b) economic planners increasingly are convinced that development is more a result of an investment in people (in their health and education) than in machinery and efficient use of this investment is possible only with community involvement.
- c) health care services are being misused and underused- a situation it is thought possible to rectify by involving clients in decisions about the development of these services, and
- d) the problems of injustice and maldistribution of health resources can be redressed as lay people especially the poor develop, maintain and control their own programmes.

Lacking investigation into community perceptions and expectation of their role in health programmes, planners have made and acted upon certain questionable assumptions about the community as an entity and about community attitudes. Many planners in the early stages assumed, for instance, that communities were fairly homogenous and that the acceptance of a plan of action



by community leaders was an acceptance for the good of and on behalf of all the community members. As a result, activities were developed that brought programme values and actions into conflict. The planners developed programmes without any knowledge and analysis of social, political and economic structures of the community despite their commitment to improve the plight of the poor.

Primary health care must necessarily have its origin in the most remote village where the problem arises. It will be better therefore to talk about community action with participation by the Government or organised voluntary agencies. The programme should be conceived and executed by the community with whatever technical and financial help may come from the Government or other agencies. We often talk of health care delivery. It should be realised that health cannot be delivered entirely as a gift. It is essentially do it yourself proposition.

The working group of the Ministry of Health constituted for finalising the strategy for 'Health For All' have reiterated the need for community participation in their health programmes. From then on innumerable conferences and seminars were held to highlight on the need for the same and methodologies to be followed. Even today such confusion exists in the matter of understanding the meaning and content of community involvement. Several tools like educational strategies, awareness programmes IEC and the like have been pressed into service for educating the community regarding health and health matters.

According to Meera Chatterjee "Many and varied attempts were made during the decade beginning with the eighties to improve management, including training several cadres and reviewing and reformulating job descriptions and work routines. Greater sensitivity was sought to be introduced into health care through motivational training of workers and managers. At the same time strategies were employed to make the system resilient to the idiosyncrasies of workers, including management information system and information, education and communication systems (IEC). It was believed that creating demand for the services through IEC would force greater accountability on workers and managers and thereby increase their effectiveness. However, the same workers who were responsible for service delivery were put in charge of IEC programmes and in the absence of inherent motivation and communication skills they gave IEC little priority. Consequently, there is continued lack of understanding and demand for preventive health care and even for clinical services such as antenatal care and aseptic delivery. Low levels of prevention have, in turn, resulted in growing need for curative services. But the public health system is increasingly unable to provide what is demanded even though

most of its resources are spent on curative care and little on prevention. There has been no abatement of this vicious circle which remains as major constraint to Indis's hopes for 'Health for All'."

The highly professed 'bottom up' approach is health planning, though a decade and half old, is yet to be seen in action. Even today several questions remain unanswered in understanding the nature and content of this approach.

Conceptual clarity is required regarding the following:

- a) The community perception of the health problems
- b) Redressal machanisms in the community for problem solving
- c) The cultural meaning and the cultural practices with regard to the different components of health care
- d) The current level of involvement in health affairs
- e) The existing relationship between the health infrastructure, the health care programmes and the community
- f) The political will and commitment for making health a reality to the people
- g) The role of community based institutions in decision making
- h) The current level of delegation of financial and decision making powers to the communities and community based institutions.

## THE ROLE OF PANCHAYATS

Ghandhiji once remarked that "True democracy cannot be worked by twenty men sitting at the centre. It has to be worked below by the people of every village."

It is a good augury that the Constitution 73rd amendment bill has been passed by parliament and ratified by the majority of the States. It is the most positive step to place peoples health in people's hands. The ICMR/ICSSR committee on Health for All had recommended placing entirely the responsibility towards community health care in the people's own hands. We, in the Voluntary Health Services have been propagating a joint sector concept, the community health care being in private sector constituted by the Panchayats and the public sector constituted by the Ivory tower referral Institutions.

According to L.C. Jain "If we are talking of economic and social development in India, it has first to be in terms of the human beings themselves. The panchayat raj experience of West Bengal and Karnataka has been that women have acquired articulation and power. In Karnataka for instance, they

stated that primary school teachers and primary care workers should come and do their work if they are to get their salary. Attendance improved to 95%.”

If we are genuinely interested in the upliftment of women and children and have to set our priorities right, we must encourage participation.

Dr. Susheela Kaushik feels that “reservation and direct election though useful, will not by themselves lead to greater participation in terms of facing attitudinal social and structural barricade currently existing for women. Encouraging women to stand for elections and participate in voting in general, political education and political training are some of the tools.”

According to her, women’s effective participation in the panchayat raj or the latter’s usefulness for women’s rights and developments will not happen if the panchayat system itself does not operate on a principled democratic and meaningful way. Every one should work for strengthening the system in general.

## **SOME KEY ISSUES FOR IMPROVING THE HEALTH STATUS OF WOMEN AND CHILDREN**

From the foregoing it is obvious that comprehensive development and health care programmes alone can see the all round progress of the women and children. Some key issues stand out which require urgent attention.

### **1. Formulation of suitable strategies and policies:**

Enlarging health services to women and children in general cannot be done without the formulation of suitable strategies at the policy level. Several operational reserach studies at the community level are required for need assessment. Specific strategies must be supported by other measures such as legal and economic. It is also not enough if the strategies and policies are laid down. An integrated action plan is required to be developed and a machanism laid to co-ordinate and oversee the programmes.

### **2. Prioritisation:**

Priorities must be based on existing and proposed data basis through community based studies. Prioritisations must lead to phased developments aimed at groups at risk, built upon existing advantages and directed at enlightened expansion.

### **3. Resource Allocation :**

The social sector investment in India has ranged from 14 to 16% in the successive five year plans. But shares of education and health have declined



from 6.9% in the III plan to 3.5% in the Seventh plan. Several other countries have been spending 9 to 10% of their resources on health alone.

Surprisingly, even this paltry allocation is not being fully utilised and fairly large amounts are being returned to exchequer due to administrative bottle necks and red tapism.

Moreover, greater resource are being spent in urban areas to the relative detriment of the rural areas. 87% of the health rupee in Maharashtra is being spent on the three major metropolitan cities. Roughly, 90% of the health allocation in rural areas goes for infrastructure. On the whole money tends to be spent on tangible, visible and politically acceptable buildings whereas a trained staff adequately mobile and provided with simple but serviceable equipment is always the principal need.

#### **4. Resource mobilisation:**

No Government however rich can afford to provide health services free of cost.

When the panchayat institutions become fully operational, they must be recognised as voluntary organisations and empowered to generate resources either by way of a cess or by way of pre-payment plan for taking care of their own health. As already stated community health must be in the hands of the private sector, notably panchayat institutions and other NGOs, and only the curative care should be in the hands of the officially provided services. Proper referral must be built up.

#### **5. Adaptation :**

Even within our own country, the MCH programmes must be adapted to suit local cultures and practices. These adaptations are called for in the field of domiciliary care techniques, health education and in the training of workers and supervisors.

#### **6. Availability of supportive health services:**

Domiciliary MCH programmes cannot succeed unless there is a back up of adequately staffed and well-equipped medical care facilities to take care of emergencies.

A number of studies have revealed that the massive growth of infrastructure, personnel and expenditure had less than optimal impact on the health status of people. Some of the reasons for the gap between effort and effect are obvious like weakness in areas like nutrition education, safe water supply and sanitation.

The system of primary health centres, though well conceived and endowed with resources, lacks leadership and managerial skills. Medical and para-medical personnel are not given adequate training in community interaction and the role of responsible leadership of the health team.

### **7. Building up of public opinion :**

It is absolutely essential that politicians and senior administrators and indeed all public leaders are made aware of the health problems in their area. Proper allocation of resources and utilisation of the available resources is possible.

### **8. Training :**

Apart from the social orientation for increasing the effectiveness of community health work, training in communication skills and managerial training are urgently required. The training programmes in the country are to be directly related to the real function in a particular community rather than to copy the traditional duties carried out elsewhere in the world.

### **9. Communication :**

The need for proper and effective communication requires no overemphasis. A massive component of communication for widespread dissemination of knowledge interspersed with social marketing Strategies will have to supplement and complement the interpersonal services. A combination of mass media and public relations by all the staff in rural and urban areas is the need of the hour.

### **10. Inter-sectoral co-ordination:**

We have men, material and even money. But human beings and departments do not understand each other. Co-ordination is required not only in overall planning but also at the practical level at health centres. MCH programmes cannot succeed by isolated methods of immunisation and nutritional supplements unless there is an improvement in water supply, environmental sanitation, housing, agricultural production and equitable distribution, income generating activities and industrial expansion - both small and large scale. There is no point in realising the value of such co-ordination unless concrete steps are taken to put the co-ordination in action.

In conclusion, it must be stated that health cannot stand in isolation, and it is essentially part and parcel of overall social and economic development. Unless people themselves organise and the Governments are prepared to

structurally alter the delivery mechanisms in favour of the community and lay down strategies and policies to enable people themselves to decide on their own programmes for health care, all well meant programmes will not have their desired impact.

Education and Health Care systems shall work together to develop fully a child's potential for learning as the state of Child's Health affects his ability to learn.

## **Age at Marriage**

A rise in age at marriage has played a role in fertility decline.

Current generation of women in developing countries is marrying later than previous generations, often substantially so. One indicator of this trend is a change in the median age at first marriage—the age by which half of women have married for the first time.

Another indicator is change in the percentage of women who married before age 20. Most surveys report that substantially smaller percentages of women age 20-24 were married before age 20 than was the case among women ages 40-44.



# 3

## CHALLENGES IN CHILD HEALTH DEVELOPMENT

### The Indian Scenario

*Dr. P. Chandra*

In this analysis of 300 million children in India and their mothers, it is tried to give an over view of their situation as well as of essential aspects of future action. This communication from a country of such size and with wide Geographic and Socio-economic differences will help in understanding the massive problem of Child Health in third world.

During the years that have elapsed since Independence, India has registered impressive progress in many fields of national activity - agriculture, industry and technology. Significant advancement has been made in modern health technology. Serveral measures have been undertaken by the National Government to improve the health of the people, women and children in particular. Many National Health Programmes were launched for the control of eradication of epidemic and communicable disease improvement of nutrition and environment. The notable achievement seen is absence of epidemic disease. Explosive out breaks of cholera following fairs and festivals, floods and wars are uncommon. Eradication of small-pox is one of the brilliant accomplishment in medical history. Data on plague indicate that for the first time in India's recent history not a single case of plague was recorded. There wer a number of on going nutrition intervention programmes for low-income groups for prevention of anemia, PEM (Peotein Energy Malnutrition)/ and micro-nutrient deficiency diseases including Iodine deficiency disorders.

India is a signitory of Alma-Ata declaration by WHO to achieve Health for all. The National Health Policy signifies the political will for achieving HFA. The target set to be achieved reveal vital role of improving MCH. The eighties witnessed establishment of clear targets for programmes of proven benefits to Mothers and children enabling National efforts to achieve previously unimaginable level of service. The Uiniversal Child Immunisation Programme (UCIP) is the best example. The adoption of infant food Bill 1992, December is an important intervention towards sound infant feeding practices.

Acute large scale famines that used to decimate vast section of populations at distressing frequent intervals during the last few centuries are unlikely to

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recur in future due to efforts of our agriculture scientists. Administration in India has now acquired considerable expertise in crisis management with respect to acute food shortage, and food which is available within and outside the Country can now be expeditiously rushed to threatend spots.

In Spite of all claims the objective is not achieved. India has one of the highest low-birth weight rate. 30%

**TABLE - I**

**LOW BIRTH WEIGHT DISTRIBUTION**

Authors	Place	Year	Lessthan 2500 gms %	Less than 2000 gms %	2100-2500 Gms%
R.S. Ramachandran	W & Ch Hospital Madras	1958-60	-	23-30	NA
R. S. Ramachandran	-do-	1963	45	20	20-25
P. Chandra	E.S.I. Hospital, Ms	1967-68	34	10	24
P. Chandra	R.S.R.M. Hospital, Ms	1975-77	31	7	24
P. Chandra	-do-	1987	30	8	22
P. Chandra	R.S.R.M. Hospital	1989	29.5	6	23.5

There had been a steady decline in birth weights less than 2 kgms and the weights between 2.1 - 2.5 kgms did not register a decline. This focuses our attention on maternal nutrition.

India also has one of the highest maternal mortality rates in the world.

**TABLE : II**

**METERNAL MORTALITY RATE**

Year	Per 1,00,000/LB
1938	2,000
1959	1,000
1980	450
1990	300-400

Pre pregnant nutrition and health, under nurition in pregnancy inadequate maternity care during pregnancy and labour are some of the main reasons.

More than 35% of all death occur in the age group below 5 years. Beneath this trend is a complex of allied factors - Maternal malnutrition, foetal under development, inadequate natal care, births too early, too many, too close, and too late . . . Improper infant feeding practices, especially the neglect of timely supplementation of breast milk, endemic deficiencies of Micro Nutrients like Iodine and Vitamin A preventable conditions like diarrhoeal dehydration brought through water food and environment and a general lack of alertness about faltering growth until it is too late for simple correction. The steady stream of rural migrants in search of work in the city, a rapid spread of urban slums and increased number of abandoned infants and children, a rising trend in exploitation and even illegal child labour and a heavy load of mostly preventable childhood disability are among the more visible consequences of the social causes underlying the over all situation of children. 40% of popluation in major cities are slum dwellers. (Table 3) - It is the children of illiterate parents who tend to keep away from or drop out of schools and who have hardly a opportunity for school preparation for learning.

**TABLE - III**

**SLUM POPULATION GROWTH IN SOME  
MAJOR INDIAN CITIES.**

Metropolitan	Year	Population of city	Slum population (Millions)	% Slum population
CALCUTTA	1974	3.19	1.44	45.00
	1981	9.16	3.24	35.35
BOMBAY	1976	7.94	3.25	41.00
	1981	8.23	4.20	51.03
DELHI	1977	5.29	1.22	25.00
	1981	5.71	3.02	53.00
MADRAS	1977	2.47	0.99	40.09
	1981	4.27	1.36	31.68
HYDRABAD	1977	1.99	0.40	20.00
	1981	2.52	0.54	21.28
AHMEDABAD	1976	1.89	0.42	22.00
	1981	2.51	0.66	26.16
KANPUR	1976	1.33	0.56	41.98
	1981	1.68	0.58	40.84



As we approach the next century certain emerging trends in the Health and Nutrition scenario need to be considered. Unlike the developed countries the "Health Revolution" (Modern health Technology) has preceded Socioeconomic development without overcoming poverty. Death control strategies like ORT, Immunisation and others have resulted in declining "conditional under nutrition" conditioned by superimposed "Nutritionally Relevant infection" had led to reduction in florid forms of PEM. "Primary under-nutrition" due to dietary inadequacy persist and large number of undernourished children reaching adulthood, progressively burdening the country with increasing number of substandard survivors. Further India has to carry multiple burden of diseases and diablement with old ones and new ones. Problems of infection malnutrition and rapid urbanisation, neurological and cardiovascular degenerative disorders and systemic diseases, visual impairment, speech disorders, mental retardation and physical handicaps increasing children in difficult circumstances and others. Emerging problems are AIDs, diseases of environmental pollution like lead poisoning fertilizer and biocide use related hazards, industrial effluents and drug addictions, Inadequacy in the availability of safe drinking water, improper disposal of human excreta, solid and liquid wastes leading to unfavourable environmental conditons and lack of personal hygiene have been one of the major causes of diseases and disability among children.

Health workers particularly Paediatricians have responsibility to address themselves aggressively to the present and emerging problems. As teachers they have a responsibility to train medical graduates paraprofessionals and others to make the delivery of health care more efficient and effective. They need to motivate students to work with new catagories of health care providers and allied professional persons who can magnify and multiply the effectiveness of the work of Paediatricians and Physicians. They have to look beyond health sector and estabilsh supportive linkages with education, health, agriculture, sanitation, communication and comprehensive socio-economic development. They have to shift the main focus from drugs and doctors to informed practice by the people for health promotion and disease prevention.

As Administrators, they have to play a multifaceted role to promote health. They have to critically and objectively evaluate what is being done, what can be done and what should be done in managing programmes. Perceptions are changing in relation to population growth. Lowering Birth Rate can not be separated from improving nurition and health, education and socio- and economic improvement. They have to play a major role in influencing policy makers regarding recent trends. They need to eliminate communication and information gap among all cadres of workers and community to make programme successful.

It has been shown that the quality of mother and child's life can be improved here and now through a cluster of community based services addressing specifically on priority need. The paediatricians have a major role to make this a reality.

The task involves not only technical specialisation but managerial vision, competence and confidence.

## **Fertility Determinants**

Building on research by Kingsley Davis and Judith Blake, John Bongaarts classified the factors that influence fertility directly, which he termed the proximate determinants of fertility. The four most important proximate determinants are: (1) the use of effective contraception; (2) age at first marriage, reflecting the start of regular sexual relations; (3) postpartum infecundability (because of breastfeeding or sexual abstinence following childbirth); and (4) induced abortion. Other proximate determinants of fertility include infertility levels, the frequency of intercourse, and spontaneous abortion.

Many policy-makers and researchers also want to measure the effect on fertility of women's education, occupation, income, and social status. In Bongaarts' framework these factors are termed indirect determinants because they influence fertility indirectly, through one or more of the proximate determinants. Because they are indirect their relationship to fertility is less easily measured.

On average, among countries surveyed by the DHS, an increase of approximately 15 percentage points in contraceptive prevalence has accounted for a decrease of one birth in the total fertility rate (TFR)

# 4 COMMUNITY PARTICIPATION FOR SUCCESSFUL HEALTH AND FAMILY PLANNING PROGRAMMES: CERTAIN NEW PERSPECTIVES

-Prof. Kuttan Mahadevan,  
Dr. V.K. Ravindra Kumar

## I. INTRODUCTION

Importance of community participation in successfully implementing health and family planning programmes gained added recognition during the last two decades after experiencing successful and isolated small scale voluntary experiments in a limited number of developing countries and in a few regions within India. In this context '*Korean Mothers Club*' is a shining example, which, in fact, has been singled out as a major determinant of success of Korean Family Planning movement. Similarly historical demography also revealed that voluntary community efforts were the principal promoters of family planning in most of the developed countries. In India too there are isolated successful experiments that exist in promoting health and family planning through voluntary efforts and active involvement of community in these programmes. In addition, the need for community participation in a big way was felt in India during the beginning of 8th Five Year Plan period, after realising the past insufficient progress of family planning programme, which was largely implemented by the Government Agencies throughout India. Incidentally it coincided with the privatisation of industrial development vigorously now being followed by the Central Government. Added to these developments in India, several international agencies also supported such initiative in these programmes. Thus, we are now committed for community participation and voluntary efforts in a big way for promoting health and family planning programmes in India.

However, we are still uncertain regarding the method of operationalising the strategy for community participation. Although a few literatures on community participation are made available during the recent past in our country, not sufficient practicable ideas have emerged, so far, in this regard (Pai

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Panandikar and Mehra, 1987; Somnath Rai and BBL Sharma, 1986; M.E.Khar 1990; Shampa Bannerjee, 1992; NSN Rao, 1992; Avabai B.Wadia (N.D. Kuttan Mahadevan, V.D.Sarangapani and G.S.Moni, 1992). Nevertheless, the last of the three authors together have succeeded in delineating certain practical strategies in their recent paper on '**COMMUNITY PARTICIPATION IN HEALTH AND POPULATION EDUCATION**' (Mahadevan, et al., 1992) but much more work has yet to be done in this direction. Under these circumstances, an additional effort has been made now in this paper to examine this problem in the light of the present limitations and the future perspective required.

However, this paper focuses on a limited perspectives in community participation for the successful promotion of health and family planning programmes for want of time. It begins with certain high priority potential representatives of the community, who need to be involved in this programme in future. They include the future adoption of '*mass women's movements like the recent anti-arrack agitation in Andhra Pradesh*', and also exploring a few new strategies on community participation including the adoption of high fertility, mortality and also backward districts by the private industrialists on attractive terms and on a time bound basis. The last part of this paper highlights on the importance of community participation in behavioural modification which discusses issues like the role of community representatives in effective communication and education, improving source credibility and acceptability of message, accelerating/changes in the knowledge, attitude and practice and also bridging the gap between these cognitive processes, expediting the decision-making process by the decision-set, and integration of innovative ideas of these programmes into the ethos of the community.

## PART - I

### II. CONTEMPORARY VOLUNTARY EFFORTS

The Indian Health and Family Planning Programme largely grew as a governmental programme till recently owing to ideological consideration. However, along with economic liberalisation measures initiated during 1990 efforts are on to involve NGOs in a large scale. According to the recent policy of GOI (1990) 'The programme has to be progressively debureaucratized and non-governmental structures will have to be promoted to provide leadership for the programme. The programme would have to be escalated into a genuine people's movement. The voluntary organisations will be associated more closely and actively with the programme in order to fully exploit their potential.

innovation, dedication to the cause, proximity and credibility with the people'. But, 'The current population policy does not as yet, suggest a well thought out programme of people's participation. It is a major gap in the policy conception'. (Pai Panandiker and Mehra, 1987). Nevertheless, a limited number of NGOs are working in the field of Health and family planning. Notable among them are: The Gandhigram Institute of Rural Health and Family Planning, The Family Planning Association of India, The Family Planning Foundation, Christian Medical Association, UPASI, Parivar Seva Samstha, Private Industrial initiatives particularly by the Tata groups of Industries and also restricted activities of Round Table, Lions club and so on. All their efforts put together do not constitute even one percent of the inputs in the on-going Health and Family Planning Programme. Therefore, urgent re-thinking and efforts in the large scale involvement of NGOs is called for now for revamping these high priority developmental programmes.

Existing evidence available on the effectiveness of NGOs in promoting these programmes according to Pai Panandikar and Mehra (1987:249) reveals that 'there is increasing evidence that wherever the programme is based on the participation of the people, the response has been much better'. These authors, in fact studied five major voluntary agencies in different parts of India - FPAI, New Delhi; GIRH & FP, Gandhigram; Vadu Project in Pune; Panchayats participation in Indore - Dhar (M.P.); and Valsed (Gujarat) on their role, effectiveness, method of activities, and reasons for success and failures. They recommended certain policy prescriptions for their large scale effective involvement in future. According to them NGOs are thriving mostly in southern and western India and negligible in Uttar Pradesh and Bihar, where they are more needed. They concluded (p.251) 'Our policy conclusion is also that the panchayats should be utilised not only for motivational role but also in the delivery system. Even the motivational role of the Panchayats today is confined to persuading eligible persons of sterilisation ... Participation of the people in the family planning programme will have to be mobilised as a matter of deliberate policy ... elected panchayats and - the voluntary agencies.... be utilised extensively for the purpose in the family planning programme'. They also suggested that women's clubs, youth clubs, farmer's organisation, and the like should be given all encouragement and their voluntary nature should not be destroyed.

Another study of a selected few voluntary agencies was recently completed by Khan (1990). He included two breaches of FPAI, Parivar Seva Sanstha, and Vadu Rural Health Project. According to Khan most of these NGOs have succeeded in developing health and family planning far beyond the



success rate of governmental efforts. However, he concluded that NGOs, thus, so far, have tended to work in very small pockets of the population and have been relatively isolated from the government. While NGOs can not be expected to replace the government family welfare programme, they can certainly have an impact at the national level, if they are permitted to collaborate actively with the government machinery. He is right in recommending that they should test various alternative strategies for successful delivery of the programme. For the future, according to the experience of this author, it is better to hand over the family planning programme to NGOs particularly in the difficult areas concentrated by resistant communities like the muslims, fishermen, tribals, and slum population rather than funding them to do less priority work in urban and peri-urban areas as had been done by certain NGOs till recently.

### **III. INVOLVE MORE EFFECTIVE NGOs**

Establishing credibility and acceptability constitute the difficult task in promoting all developmental and welfare programmes in developing countries. Very often these factors are not given serious consideration by the programme managers and change agents. In fact the present day stagnation in acceptance of temporary contraceptives like IUD, injectable, condom etc., stem out of the crisis faced by the client with respect to their safety, side effects, and loss of personal comforts. It is also true with respect to health innovations like certain immunizations. When these requirements of clients are satisfactory, their credibility and acceptability are enhanced and there is a great scope to promote these programmes in an expeditious manner. For this purpose, of course, for the first instance, continuous technological improvement of these products may continue without compromising on their quality. Secondly, appropriate and effective community participation can enhance the credibility and acceptability. Inadequate and improper community participation can be singled out as a major barrier for the stagnation or failure of these programmes mentioned above. What can be done to overcome this problem? We may examine them as follows:

Let us consider who are the important and high priority members of a community and who can deliver the goods, in enhancing credibility and acceptability of health and family planning programmes? It may vary from one community to another community and not one but several representatives of the community may have to be considered important simultaneously to enhance the outreach of the programme through credibility and acceptability to all sections of the community. Since most of the rural communities are heterogenous in



character, with hierarchical set up, group formations, differences in development and culture, suitable, and adequate representative members of the community must be involved in the promotion of the programme. A few such categories have already been listed out in an earlier paper by this author are: Important dimensions of community power structure and credible persons are: (1) teachers; (2) community leaders; (3) indigenous medical and service personnel like Ayurvedic, Unani, and Homeo-Physicians, dais, barbers, astrologers, traditional messengers, tailors, washermen; (5) money lenders, and employers; (6) satisfied and stigma free innovators; (7) members of film fans, sports clubs; youth clubs; (8) office bearers, voluntary agencies like Rotary and Lions clubs; (9) caste and religious organizations (10) trade unions; and (11) political office bearers (Mahadevan, et al., 1992:55). In fact the importance of some of these representatives of the community has already been dealt with in an earlier paper. Therefore, only a selected list of voluntary agencies and indigenous service persons alone is examined here in detail in the pages that follows:

**III. 1. INVOLVE MUSLIM LEADERS AND PRIESTS:** Are there not many other voluntary agencies in India, who can be involved in health and family planning programmes? In every Indian state including the backward - Uttar Pradesh, Bihar, Madhya Pradesh, Orissa, Rajasthan and North-eastern states, there are age old religious and caste organizations, service organizations and so on. If the office bearers of these organizations are invited by the Chief Ministers for a dialogue for their participation in these programmes and offered incentives for financing their welfare activities, we are sure that the base of NGOs can be expanded for strengthening health and family planning programmes. For instance, did not our Prime Minister succeed in bringing several hundreds of Muslim leaders from all over India to New Delhi in October, 93 for discussing their common problems including the enhancement of their monthly remuneration. This meeting held on the eve of elections in the 4 states in India, really benefited the ruling party to minimise the alienation of Muslims from their party fold. Should not we repeat similar meetings of various communities periodically be held for promoting health education and family planning. Why not finance them and make time bound deal with them to make these programme significantly successful during a short period of time? Why not other office bearers of village artisans, barbers, carpenters, goldsmith, washermen, tribal chiefs, co-operatives of fishermen, and such other NGOs be periodically brought together, informally trained, and arrived at a contract with them to develop these programmes through their voluntary efforts, of course, with the financial and organizational backing of Government and with other attractive incentive offered to them.

### **III.2. INDUSTRY FOR ADOPTION OF DISTRICTS:**

Private industries in India have made rapid strides in to progress during the last two decades. It is an opportune time to make them adopt high mortality and fertility districts to promote industry, health and family planning programmes simultaneously. Give them tax holiday at least for 5 years if they achieve 75 per cent CPR in the adopted districts within 5 years time. Give them loan with low interest in such adoption programmes as an additional incentive. If this programme is seriously taken up at least by 25 big business houses, India, can stabilise population growth in backward districts of Uttar Pradesh, Bihar, Madhya Pradesh and Rajasthan, before the turn of this century, which may be a great boon to family planning in India. Gradually this experiment can be extended among many more industrial houses. There is no use in blaming NGOs for not coming forward to promoting health and family planning programmes, in the absence of definite incentives offered to them on a time bound basis.

### **III.3. MASS MOVEMENTS OF WOMEN: THE ANTI-ARRACK AGITATION IN ANDHRA PRADESH:**

The anti-arrack mass movement organised by women of Andhra Pradesh in 1992 was both a spectacular and phenomenal success. It was a pure voluntary mass movement by the middle income group and working class. This movement was spontaneous, peaceful, and successful in pressurising Andhra Pradesh Government to close-down all arrack shops throughout the State of Andhra Pradesh surprisingly in a matter of few months time. How was it originated and spread will be a useful lesson for awaking up women for family planning programme in India.

This anti-arrack movement was first originated in Nellore district where adult education centres empowered illiterate women and awakened their awareness against several social evils including the injurious effect of drinking arrack by men folk. Such sessions were ably imparted first in Dubagunta village in Nellore district. The leadership for this adult education in these centres was provided by ordinary women trainees and women teachers at the adult education centres. Subsequently certain trainees of these centres along with their teachers first organised themselves to protest against selling of arrack in Nellore town. Their fight against selling arrack continued for some time and mass media gave full coverage to this small scale protest and slowly it spread like wild fire to other neighbouring districts in Rayalaseema region and ultimately to all the districts in Andhra Pradesh. How it was spread will be an interesting experience for all social scientists, reformers and educationists.



The political patronage extended by Sri.N.T. Rama Rao's Telugu Desam party to anti arrack movements intensified this movement very fast and spread it throughout the state. Several district level, Taluk level and village level, mass meetings were jointly organised by TDP and volunteers/office bearers of anti-arrack movement. Such meetings increased the enthusiasm of all women, who were the actual worst victims of drunken husbands for years in the past. In fact, liquor use in Andhra Pradesh is far more extensive than in many other states in India. Their latent sufferings, motivated them to be bold and active enough in associating themselves with anti-arrack movement. When this movement received full political support, financial backing and organizational back up from TDP, the agitated and motivated women intensified their efforts forcing the present Chief Minister Sri Kotla Vijaya Bhasker Reddy to close down arrack shops first in a limited scale in Nellore district and subsequently in a phased manner extended the same to all other districts in Andhra Pradesh in a matter of few months only. *It is a very rare successful women's mass movement ever that happened in the history of our country.*

This massive, voluntary and effective anti-arrack agitation provides valuable lessons for health education and strengthening voluntary efforts in promoting family planning in India. On experimental basis integrate family planning with adult education programmes and extended financial support and organizational back up, the selected women activists can begin similar movement in favour of: (1) raising age at marriage of girls; (2) stopping dowry; (3) a no child-birth year after marriage and in 1994; and (4) stopping child bearing after two live children. Should we not learn lessons now drawing inspiration and experience from this spectacular successful mass women movement very fast for the promotion of these programmes. Well as an in-depth study of this movement, it is also urgently necessary to generate data to use the findings of this voluntary movement for future efforts.

## PART - II

### IV. COMMUNITY PARTICIPATION FOR BEHAVIOURAL MODIFICATION

As a result of effective community participation in Health and Family Planning Programme, it is assumed that a series of several and successful processes and changes may happen over time. These processes can be provisionally classified under five major progressive changes. They may form (1) effective communication and education; (2) source credibility and acceptability of message; (3) changes in KAP; (4) decision making for adoption; (5)



integration with community ethos. They may move from one phase to the other preferably as a sequential process but may occur concurrently also depending upon the nature of the programme and level of development of the clients. However, normally it is assumed that these changes take place over a considerable period of time and, hence, to be sequential in their process and change. Therefore, it is interesting to explore the details of these processes in the context of variegated effectiveness in community participation.

## **1. EFFECTIVE COMMUNICATION AND EDUCATION:**

Effective communication is an ideal proposition, which seldom happens under normal circumstances, either through mass media or interpersonal sources of communication. Unless credibility is built into the communication process and effectiveness in dissemination of message is assured, communication of ideas may go waste. In fact, many efforts of present day communication of health and family planning messages go waste as they are not communicated through suitable media, with effective style, and treated credibly. In addition, very often message is not conveyed in attractive and easy comprehensible lines. For instance, a shop keeper or a T.V. manufacture conveys the ideas about his saleable products to the customer very intelligently, in a simple and, attractive and effective way to catch the very imagination of customers for expeditious and favourable decision making for acceptance of brand new goods and products. Why not the change agents/mass media succeed similarly in communicating the message on importance of small family norm, family planning and importance of immunization methods. Well, it is partly due to failure in communication strategies as well and partly noninvolvement of the community effectively.

Suitable and effective community participation can make the communication most effective and successful. How it can be accomplished? For different clients in a community, different types of media are accessible, and acceptable. Their credibility of the media also differs. For instance, how many people own TV sets, radio sets and listen to health and family planning programmes? How many people can read and write and are accessible to print media? How many of the large number of locally available and credible interpersonal channels of communication are tapped to convey the message on these programmes? For instance, if all the artisans like the barbers are suitably trained and equipped with Health and Family Planning messages and their shops are provided with attractive messages on these programmes besides vested with condoms for marketing atleast monthly once, they can directly and indirectly reinforce the message on these programmes most effectively and distribute condoms to a cross section of an EC. Similar advantage can be created through several other

artisans like washermen/ women, astrologer, indigenous physician, different categories of vendors, shop keepers and those who have much contact and acceptability with all clients. All these channels may have differential access and credibility to different clients. In addition, multiple channels of communication may reinforce the message leading to early behavioural change. Similarly all the available traditional and modern mass media must be effectively tapped for successful early and effective dissemination of health and family planning messages.

Education is the major casualty in extension programmes by the peripheral workers for various reasons. In the context of multi-purpose programmes and existing unmanageable worker population ratio, under the existing unfavourable infrastructure, where is the time and scope for health and population education? In addition, for the majority of illiterate or semi-literate eligible clients peripheral workers are very often not still able to impart enough education on several themes of health and family planning in a manner and through method suitable to the clients. In fact, the peripheral providers do not visualise the suitable timing, context and frame of reference for education and act accordingly because they work according to their convenience and timings and it may not be suitable always to the clients. Hence, where is the scope for meeting ground for appropriate climate for imparting them with education? Under these circumstances, generally the less motivated majority of clients do not get the required messages on much essential knowledge of these programmes. On the other hand, when motivation of clients reach higher level, whatever be the existing constraints of facility, they may venture to reach the peripheral personnel or experts to acquire, much needed knowledge, which is very rare for many clients.

What type of community representative will be suitable for imparting education may further require careful consideration. Since most of the convenient and effective representatives of the community may not be sufficiently educated in rural areas, they need to be educated only on certain limited importance of priority areas of health and family planning programmes, the misconceptions and rumour that might spread in course of development of these programmes. They cannot be expected to replace the role of peripheral providers as they will not agree to the same and it is nor feasible also. Then the question is who are the suitable community representatives for such education. They must be those persons who frequently interact with the community like the indigenous physicians, local tea shopkeepers, barber, and such other local artisans, local opinion leaders, traditional dais and the like who are listed out in another section in this paper. When such educators are periodically given orientation training, they can form the permanent, widely and readily available



and acceptable channels of communication for continuous education on health and population. Did we, so far, sufficiently explore such potential supplementary educators of the community to augment the efforts of peripheral educators and if not why do not we try now.

## **2. SOURCE CREDIBILITY OF MESSAGES:**

Involvement of community representatives in communication, education and even supply of conventional contraceptive, can certainly enhance the credibility of these programmes. It is because very often the peripheral providers are strangers to the clients and such 'Outside persons' alone according to several eligible couples may not be fully acceptable to them and not to speak of the credibility of their service. It is because people do not perceive them as competent persons like a doctor, whose message is acceptable to people because of either safety or competent credibility. Under such existing crisis of acceptability and credibility certain selected community representatives can bridge the void in this context. In fact the peripheral providers at least for some time initially work along with such local people to gain credibility and acceptability. Otherwise they may always remain as 'Outsiders' to several clients. Who can be the right choice for this purpose? Well, certain persons with status and quasi-professional people who have good images as capable of clarifying the confusion of clients may have to be enlisted for this purpose in rural areas. If they are effectively and extensively oriented and involved in these programmes these representatives of community can bridge the existing void in the field of dissemination of message and distribution of conventional contraceptives. Such involvement of community representatives is not for replacing peripheral providers but to reinforce their service and to make their service more credible and acceptable to the community at large.

## **3. ACCELERATING GAP IN HEALTH AND FAMILY PLANNING:**

Although certain explanations are available on the existing gap between knowledge, and attitude on the one side and on the other between attitude and practice, a major explanation on this existing stalemate is the absence of adequate community participation under these programmes. So far, adequate attention has not been paid to explore how community participation can accelerate the pace of development/ change in the KAP in health and family planning innovations. In fact, it is a high priority area of action research now. It is generally assumed that most of the representatives of community referred to at the beginning of *this paper*, may help in improving knowledge and changing attitude *in favour* of these programmes, but adoption is subject to still higher



level of credibility of the message. Therefore, for awareness and attitude change, use as many community representatives as possible but, for clinching the stage of adoption use selected and relatively more credible change agents. In this context a satisfied adopter and particularly a satisfied community leader and his spouse, indigenous physicians and dais may be relatively more suitable to act as a bridge between the clients and formal providers of these programmes. Their involvement on a regular basis in the motivation programme can minimise the 'prolonged time lag' in adoption of contraception. Of course, it can serve to reduce the time lag if only the clients defer adoption owing to poor credibility of message they received, so far, and all other major barriers of contraception have been removed or reconciled. For instance, if a number of clients suffer from unfounded fear of sterilization but prepared for family planning, for such clients community participation can really benefit for their expeditious adoption of sterilisation. On the other hand when contraception is delayed for the sake of getting an additional sibling particularly a son, community participation alone may not be sufficient but other social security measures from the government side may be parallelly and timely needed to expedite the pace of adoption of contraception. Therefore, the peripheral providers may have to analyse the situation and background of each client to tackle different and diverse clients on a judicious basis.

#### **4. DECISION - MAKING FOR ADOPTION:**

Decision - making in favour of acceptance of family planning method or immunization programme is a complex process. In this process, imagine how many people are involved, who dominate the final decision, how cultural taboos affect it, and in what manner psychological phobias facilitate or deter or delay the decision. In fact, very often most of the decisions are inordinately delayed and not made and some times indecision prevails. Under such circumstances, what role community participation has in reducing delay and facilitating favourable decision making among the members of the decision-group. While most of the decisions made for acceptance of a contraceptive method and so also immunization of a child are collectively made in the family and in the rural community, we generally assume and extend the education exclusively to the clients. Think for a moment how far it meets the genuine requirement to speed up favourable decision-making. Therefore, let us have a rethinking on how community participation can bridge the existing efforts on education for favourable and expeditious decision-making for acceptance of health and family planning programmes.

Empirical evidence confirmed that a couple as a unit constitute the core group of decision-making. But very often, other members of the family and neighbourhood like the experienced early adopters, traditionally familiar

indigenous service personnel and other source credible persons have either direct or indirect and also different degrees of involvement in arriving at a decision of a couple (Mahadevan, 1994). When selected community representatives are associated with these programmes, they form effective out-reach for dissemination of message to all the relevant members of the decision set, which make decisions, easy, fast and favourable. Very often we also do not imagine what happens to the chain of interactions that follows in a family or neighbourhood soon after a peripheral worker visits and enquire about the programmes. In fact a debate on the pros and cons of the programme takes place within the family and between the neighbours soon after the exit of the worker from the village. These workers may again visit perhaps after a month or two only in the same village. Till such item majority of the members in the family and neighbourhood, who were not exposed to health and family planning messages, will be interacting with the minority of eligible couple who were alone exposed to 'partial education' on these programmes. As a result favourable views in such group interactions will be subdued with the views of many other local people who have not been exposed to the details of the programme and perhaps with their unfavourable attitudes. Such eventuality is not very often anticipated in the education strategy of present day programmes.

When most dimensions of community at large are involved in the programme and exposed to education, they can help favourably in decision-making, at the family and community level, which is a continuous and long term process in a less developed and traditional society. Therefore, anticipating the pattern of interaction in different communities the network of education may suitably be expanded to cover all the participants of decision-making. Of course, identification of participants of decision-making requires community-wise studies and research findings. Involvement of experienced social scientists can overcome the problem of identification of participants in decision-making. With such realistic expansion of education to relevant and influential members of decision-making group with such outreach in education, we can break the existing stalemate and long term delay in acceptance of health and family planning innovations.

## **5. INTEGRATION WITH COMMUNITY ETHOS:**

Innovations like the modern family planning methods and immunization programmes, introduced in a traditional society reject like a transplantation of an alien organ made on a human being. The transplanted organ may merge with host body or may be rejected depending upon several factors. Similar is the case with regard to integration of an innovation with the community ethos. These health and family planning innovations can be slowly and steadily integrated



with the community, when they are made to accept first by the gate-keepers or power structure of the community like the influential, important, respectable and other status persons in a concerned group. Normally subsequent wider acceptance of any innovation takes place through diffusion process. Such process of diffusion will flow smoothly leading to final integration of innovation into all dimensions of a community, when the programme implementation follows the principles underlying the diffusion theory. On the other hand defective approach in programme implementation leads to a stagnation of programme implementation or its failure in the community at large. Once, the programme is made to advance on sound lines, it will be automatically perceived as an integral part of the community leading to the ultimate integration with the community ethos.

Thus, in this paper certain new perspectives in expanding and effectively involving potential representatives of the community in promotion of health and family planning have been highlighted. Among such agencies, a selected few effective strategies like mass movements of women in anti-arrack agitation in Andhra Pradesh, and adoption of high fertility and mortality districts by industrialists for rapid industrialisation and control of these vital events have also been recommended as viable and effective new strategies. It has also briefly gone in to deeper aspects of behavioural modification through the intervention of community participation. In order to extensively use influential and resourceful representatives of the community in health and family planning programmes, an exhaustive list of such agencies has also been provided.

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# 5 PSYCHOLOGICAL AND SOCIAL ASPECTS IN MOTHER AND CHILD CARE.

*Dr. (Mrs) Beulah Rabindradas.*

## INTRODUCTION

Eventhough health has been defined as a state of complete physical, mental and social well being and not merely the absence of disease or infirmity, all health programmes generally give more importance to physical health aspects rather than mental and social health. Needless to say that equal importance should be given to mental and social aspects also. This paper discusses some aspects related to Psychological as well as Sociological factors in mother and child care.

## IMPORTANCE OF MOTHER CARE

The mother has greater opportunities than the father to influence her offsprings psychosocial development and behaviour. Tradition also favours the mother's influence, since child rearing in our culture is generally recognised as primarily the mother's privilege and responsibility. The parental system of drives, is generally supposed to be strongest among women. It is indeed very probable, that is only amongst women, possibly only during the period after birth, that there is a strong system of parental drives resulting from internal secretion. On analogy with result obtained by Wiesner, it appears that lactation itself is not productive of this maternal drive but the emotional experience of feeding the child at the breast increases the mother's tender attachment to her child. The system of drive is called 'Maternal Instinct. However parental love does not depend entirely on the strong drive which exists in the mother soon after birth. These form the foundation for sentiments of parental love which remain powerful source of motivation.

## ANTECEDENTS OF EMOTIONAL BOND

The woman who gives birth to her child rather easily and quickly with relatively lesser labour pain is likely to have a relaxed attitude towards the child

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and may provide a healthier emotional climate for the child, as compared to a child born to a mother under prolonged and difficult labour. In the latter case the mother, may become over protective of the child and this is even more likely if she has been warned by the doctor of the danger of future pregnancies.

## **RISKS OF FAULTY MOTHERCRAFT**

Mothers who endanger the health of their children by giving them infected milk from dirty vessel are those who lay the foundation for later neurosis in their children by systematic overprotectiveness.

One of the effects of the maternal attention is that both boys and girls prefer their mother's presence, when they encounter difficulties. There is some evidence that the overprotective mother has an unusually deleterious effect of her child's social and emotional growth.

SPITZ, a psychoanalyst-physician has published a series of papers on the adverse effect of mother-infant separation. These deleterious effects are at maximum during the second six months of life according to his experimental findings. These children displayed a marked retardation in perceptual tasks, and motor development. They became socially withdrawn and depressed and failed to make normal progress in physical growth. The above mentioned effects may be displayed if the child is reared in a creche during very early stages.

## **EFFECTS OF ILLNESS ON THE PERSONALITY**

Regardless of whether an illness is physical or psychological in origin, chronic or transitory, mild or intense in nature, if prolonged and are accompanied by unfavourable attitudes by the mothers or attendants, it brings changes in the development, behaviour, attitude and personality of the child.

## **DEVELOPMENT OF EMOTIONAL BONDS**

Human infant must spend years in a state of dependency. During this period, his needs can be satisfied only through others (mother and father). The infant learns that the presence of others is related to the satisfaction of physical needs — that is satiation, warmth, comfort and safety.

Human organism has a need to be loved or to receive attention. If the need for love or attention is not met in some way the organism may develop pathological symptoms and may even die. This idea runs through much psychoanalytic thinking about mental health. The child is attended to by mother and her tender and loving care accompanies the routine that gives him pleasure.



Soon the infant begins to show pleasure in the presence of his mother and stops crying when she approaches. During infancy it is also the mother figure who introduces the first pressures or demands. The child must learn to adjust himself to a feeding schedule and control his bowel and bladder. This compliance mechanism with parental demands will help him secure parental affection and latter help him develop trust on them. If parental affection is not enough the child suffers emotional setback, and thereby learns with some difficulty control over feeding and elimination behaviour. The desire for parental affection is threatened to some extent by a newly arrived sibblings and may develop with sibbling jealousy unless the parents show some restraintment and balance with protection and love of the new born. Sufficient spacing between the children may help in this regard.

Lack of time for the mother to play with her child, relative rejection of child's dependency, relative absence of reasoning as a method of training, was found to be associated with the development of feeding problems, persistent bed-wetting, and high degree of aggression.

## **CHILDREN'S PERCEPTION AND ATTITUDES TOWARDS THEIR PARENTS:**

Children's attitude towards their parents is an interesting and highly significant child-rearing antecedents. The boy who develops resentment and hostility towards his father tends to resent others during later life. Positive emotional attachment to parents seems a necessary antecedent of the acceptance and internalisation of parental attitude and values. People tend to see their own behaviour tendencies and personality traits in people whom they like. Boys who perceive themselves as being highly similar to their fathers tend to show the most favourable personal and social adjustment.

## **EFFECTS OF PUNISHMENT AND REWARD**

Punishment was found to be far less effective than reward for changing the child's habitual way of behaving. Punishment was associated with greater dependency, more aggressiveness, less stable toilet habits and slower development of conscience.

## **BEHAVIOUR TENDENCIES OF THE CHILD IN THE FAMILY:**

Parents are themselves influenced by the developing behaviour characteristics of their children. The behaviour system of the child in relation to its

parents is an acquired system of behaviour based on original innate pattern, that is the behaviour system of the parent to the child or of the parents towards each other. Methods of positive control may produce child hostility and aggression which may in turn eventuate in sterner attempts at control for an ever widening circle of mutual frustration. The mother or father who attempts to curb independence in the pre-school child may be disappointed with the dependent attributes of the same child in pre-adolescence.

The child plays an active role in his own social emotional development. He is no longer viewed as a passive recipient of adult influence; he is regarded as an active and influential partner in promoting his own development. Cognitive and biological factors are viewed as important determinants of social emotional development. The child is embedded in a variety of social systems and settings in which various agents shape his social emotional development.

## **NEED FOR COMPETENCE AND SELF RESPECT FOR THE CHILD:**

A happy and effective person has goals to which he is committed and he is capable of accepting his real limitations. The infant does a great deal of manipulation and finds joy in observing its effect. During early childhood crawling and walking are exploratory rather than directed towards useful goal. Independence requires that a person should express his own will and act spontaneously with confidence while retaining a balance of self-control. Independence is learnt gradually and with continuity.

## **DEVELOPMENT OF EMOTIONAL LIFE FROM EARLY INFANCY:**

Emotional outburst start in early infancy and are more overt and apparent. During infancy and situation that blocks the natural course of satisfaction of a child's interest or desires may cause an emotional stress. Sometimes the child wants to accompany the parents in their outing but they would not take him out. The child starts crying out as a result of emotional strain caused by this parental rejection. In order to pacify the child, the parents may give him a doll to play, but at that moment the child would not like that substitute. He was eager, to participate in adult activity that was denied to him. The child shows his vengeance on the doll which becomes an object of parental deception. His vengeance may assume a form of cruelty. This is gradually formed into a habit and the child gets cross and peevish and throws up tantrums. TO AVOID THIS WE MUST, UNDERSTAND THE CHILD AND HIS NEEDS OF THAT



**PARTICULAR MOMENT.** When the child wants to go out with adults, he is interested in human company. If he has to be kept back at all, he can be given the company of others of his age group or let some one else take him to another place.

Weaning is a critical stage for emotional development. As the teeth appears, children often develop symptoms of severe malady and the food habits change. Breast feeding has perhaps been stopped and the child hurts his mother by his teeth. To the child the reason for this stoppage is not clear. He thinks he is being deprived of a privilege which had been his birth right. Probably at this time, a second baby is born into the family and seems to monopolise the mother. At this time it is natural for the child to become jealous of the new arrival, thinking it to be responsible for all his loss. This antipathy is often expressed in a violent form, sometimes hurting the baby.

After weaning while the child is engaged in individual games, he is somewhat self-centered and seldom displays violent temper unless he feels that he has been unduly deprived of some of his due or thwarted in his activities. Sickly and underdeveloped children who are unable to engage themselves in play activities are however possessive and emotional perhaps somewhat peevish and self-centered. They will not want adults to pay attention to anyone but themselves. They do so because they have nothing else to distract them. Wise parental direction can cure this. But many parents overlook this and children sometimes start life without being properly weaned.

As a frustrating emotion, anger is the most common feeling which has its beginning in infancy. Anger may vary in intensity from simple resentment or irritation to an outburst of violent rage. A child hit by the parents cannot hit them back but he hits his younger brother or a doll, just to provide an outlet for his pent-up feelings. The best way to prevent this frustrating emotion in a child is to prevent development of situations that may foster in. In case of punishment the child should understand why he is being punished.

Fear may assume forms ranging from mild apprehension to paralysing terror. But in all cases a feeling of helplessness to meet the situation seems to be the origin of the fear. A child who is continuously afraid feels more and more helpless and is ultimately unable to accomplish anything.

A feeling of pleasure motivates us to push our way forward. Satisfaction gained from an activity serves as tonic helping us to overcome fresh barriers. To produce this effect we are offering rewards and prizes. Of all the restoring emotions that a child needs most in mother or father is affection. The lack of sympathy in broken homes makes a child delinquent. If children reared in a hostel or in an orphanage are sometimes hard hearted and self-centered, the fault lies in the fact that they have missed this vital tonic in their upbringing.



Affection of parents, if wisely bestowed, will be helpful for the normal development of children and such children will be more amenable to discipline than others who are always harshly treated “it is far better to rule by love than by fear”.

## **SOCIAL CONSCIOUSNESS OF CHILDHOOD:**

At its very birth an infant has no special consciousness. He however finds his needs being fulfilled by his mother, on his very existence. The fundamental form of social relation which consists of two beings mother and child. Social consciousness gradually develops from simple mother and child relation to an interest in other adults and then to an interest in one's own age group. To a great extent the child's behaviour towards his group is determined by his family upbringing. If a child comes from a home where parents especially mothers are irresponsible, he will compensate for the parental neglect by unduly showing off in his age group children. Those coming from homes where parents constantly quarrel may become very aggressive. The children who come from homes where understanding and cooperation of the adults is blended with wise guidance, are cooperative and have the spirit of ‘give and take’.

A child's first contacts with social learning occurs in the home. The effects of home atmosphere are important in moulding the child's personality. Studies show that permissive democratic homes encourage and reward curiosity, exploration, and expression of ideas and feelings. On the other hand, highly controlled, over-protective homes tend to discourage independent behaviour, exploration and experimentation. The child becomes more timid, apprehensive and generally conforming home atmosphere and parental guidance contribute to the personality characteristics of the child.

## **ADJUSTMENT MECHANISM OF THE CHILD:**

Adjustment mechanism are the habits by which people satisfy their motives, reduce their tension and resolve their conflicts in a narrower sense; defence mechanism means indirect or substitute habits of adjustment. Defence mechanisms are not acquired deliberately. They are mostly unconsciousness and unverbilised. Attention getting is one of the most primitive defence mechanism. For a baby to cry is normal and useful. When an older child has unfulfilled needs or unresolved conflicts and has not learned to get adults help in other ways, he may remain a ‘cry-baby’. Little children have many attention getting habits such as making noise, and asking interminable questions, refusal to eat is a common way of attracting attention. Deliberate disobedience is often

an attention getting mechanism since to be scolded is more satisfying than to be ignored entirely. Bed wetting, thumbsucking, running away, complaining of injuries and ailments etc. are also coming under attention seeking mechanism. A small child has limited capabilities and is constantly controlled by his parents and other adults around him. In turn he seeks to control them and gain their attention. There is no set formulae by which parents can deal with attention getting service, each child's need and conflict differ. General principle is to give warm genuine attention to the child as a person.

Defence mechanism helps an individual to control their anxieties regardless of consequences. Adjustment through defence often is achieved at the cost of bringing discomfort or even harm to other people and failing to provide satisfaction to the person himself. For example, 'A widowed mother depended on the eldest son as the 'Man' of the household, showed affection on the youngest son. The middle child was left out. So he started stealing. Stealing was his life of thrill and adventure, a compensation for his lack of satisfaction at home.

Some general advise to parents: Optimal child-rearing practices should help the child to develop social needs which are in harmony with the major social values of his culture.

1. Environmental factors that promote optimal physical growth and health; adequate nutrition, protection from diseases and physical injuries.

2. Environmental factors that promote optimal perceptual motor, intellectual and social skills-abundant learning opportunities when the child is maturationally and experimentally ready for them, social stimulation to realise his potentialities for further growth, appropriate guidance for his learning efforts, opportunities to make mistakes and profit from them.

3. Environmental factors that optimise stability: A secure home in which affectional blends can be permanently established, consistent methods of discipline and socialisation opportunities for the release of emotional tensions.

4. Environmental factors that promote acceptable values - parents provide reasonably acceptable models by their own behaviour, approval and disapproval used in a consistent manner to reflect the personal-social values of the home and the larger community, and child should be given opportunities to participate in the activities of various agencies and institutions designed to transmit social values.

5. Environmental factors that promote initiative, flexibility, self-responsibility and self understanding - freedom to explore permissive attitude in the home, democratic structure in subgroups to which the child belongs, encourage and examine his needs, purpose and potentialities for further growth.

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## *Section 2*

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### *Programme Aspects*



# 1 COMMUNITY ACTION FOR HEALTH

(Working Paper for the Technical Discussions)

## 1. INTRODUCTION

It has been identified in the Eighth World Health Situation Report (1992), which is based on the Second Evaluation of Health for All (HFA) Strategies, that in spite of achievements in the health status and health care coverage, viewed nationally or globally, there is still a wide gap as shown by disaggregated information. The development and implementation of policies, financing, organization, and management of health and health-related programmes are further complicated by the fast changes in the global political and socio-economic situation and epidemiological transition that have taken place in recent years in all countries, especially those in the South-East Asia Region (SEAR). Changes in the epidemiological situation have also been linked to changes in lifestyle and worsening environmental conditions, coupled with rapid population growth.

Therefore, Member States have been urged to maintain a high level of political commitment to social equity and leadership for accelerating the implementation of national strategies and to pursue vigorously actions aimed at strengthening the management of health systems based on primary health care (PHC). In this regard, emphasis is laid on efforts to maintain collaboration with all health and health-related sectors and to develop effective mechanisms for their sustained support. One of the effective mechanisms would be to strengthen district health systems based on primary health care and identify appropriate targets for integrated delivery of essential elements of primary health care and implement them until all districts and all elements are covered (World Health Assembly resolutions WHA39.7, WHA41.34, WHA42.42.2, WHA45.4 and WHA46.17; SEA Regional Committee resolutions SEA/RC40/R5 and SEA/RC41/R4).

While the basic principles and concepts of Health for All and Primary Health Care are still alive, yet there is an urgent need for new orientation in approaches and strategies. This requires that the health sector pays more attention to the intimate relationship between health and development, and intensifies community action for health.

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World Health Organization, Regional Office for South East Asia

Regional Committee, Forth-sixth session, Provisional Agenda item 11, SEA/RC46/14 7 July 1993.



The Concept of 'Community Action for Health' (CAH) had its roots decades back. Different terms are used to reflect people's role in health development, such as community participation, community involvement, community action and social control. These are loosely used to indicate the varying degree of action by the community, starting from self-action to full control by the community as a whole.

The term 'community participation', as defined in the report of the International Conference on PHC, held in Alma-Ata in 1978, refers to the process by which individuals and families assume responsibility for their own health and welfare as well as for those of the community, and develop the capacity to contribute to their own development and of the community. This enables them to become agents of the development instead of remaining passive beneficiaries of development aid.

The term 'community involvement' is preferred rather than 'community participation' as the former reflects the need for a deeper and personal involvement. A WHO study group observed, in 1989, that community involvement in health (CIH) is essentially a process whereby people, both individually and in groups, exercise their right to play an active and direct role in the development of appropriate health services, in ensuring the conditions for sustaining better health, and in supporting the empowerment of communities for health development. CIH also implies a partnership being established between individuals, community groups and organizations (government and non-government) in planning, operation and control of health activities using local, national and other resources.

From the above flows 'community action for health', which, in effect, lays emphasis on individual and group action side by side to attain an acceptable level of health of both the individual and the community.

The attempt here is to assimilate what is community action, what are the key factors which facilitate or hamper such community action, and how to deal with them; and not to come up with specific and explicit definitions for these.

## **2. ENTRY POINTS FOR COMMUNITY ACTION FOR HEALTH IN SOUTH-EAST ASIA**

The recent trends in political and socioeconomic systems and disease epidemiology in SEAR countries had a profound effect on community action for health. Generally, there is a genuine desire among people to participate in, and contribute towards, overall health development. The development of CAH is a continuous one with several entry points, based on experiences gained in implementation within each country and elsewhere.

It can be identified from the experience of SEAR countries that there are two main areas of entry points in regard to CAH, viz., health or health-related development, and social development with health as an integral part.

## **2.1 Health**

Many health development schemes in the countries of the Region are initiated and supported by either government and/or nongovernmental organizations (NGOs) utilizing community health volunteers in both rural and urban areas; some of them have resulted in successful experiences in strengthening community action for health.

Health committees have been established at the neighbourhood, ward and village levels in urban and rural areas for planning, coordination and implementation of health activities. Their effectiveness depends on many factors such as pattern of administration, decentralization of authority and responsibility, support from within and outside the community, process of selection of priorities and political power structure that prevailed at the local level. The capability of the local leadership and the strength of local administration at the village/community level form the key for success or failure of community-based activities.

Another feature of promoting CAH is the involvement of mothers groups/ mothers clubs in organizing activities in support of family planning, maternal and child care, and prevention and control of diseases affecting them.

Drug cooperative schemes managed by the local community helped in providing cheaper and effective essential drugs at the doorsteps of the community simultaneously ensuring the quality of care. Such schemes have been initiated in several countries such as Indonesia, Myanmar, Nepal and Thailand.

The active involvement of sex workers, community support groups, religious leaders and NGO's in collaboration with the Governments of India, Myanmar and Thailand, in the prevention of epidemics of AIDS/HIV infection recently is another example of entry points for CAH.

To cite, the "Little Doctor" or "Dokter Kecil" programme of Indonesia trained school children to serve as prime movers and motivators for changes, promoting better health in the school, the home and the community. Child-to-child and child-to-family education programmes are the other useful entry points.

Community health volunteers (CHVs) have been utilized as valuable human resources for health development providing information on health



promotion and disease prevention, simple curative care for common diseases, and appropriate care during pregnancy and childbirth. In most countries, CHVs have contributed significantly to national health development efforts. The profile of CHVs as well as their training, duties and responsibilities vary from country to country.

Implementation of integrated health care packages at the service delivery points has strengthened CAH. The packages improve access of the local community to health care and also provide mechanisms for functional integration and for frequent interaction between community and health care works facilitating a sense of partnership and providing supportive environment for community action. Better results in health care coverage and equitable health status can be achieved through packages addressed to women and children who require frequent contacts for various health interventions, such as immunization, maternal care, family planning, nutrition education and growth monitoring, diarrhoeal diseases, ARI control, etc.

Young or old, government or non-government, political or non-political, individuals and community are motivated and fully involved for action on mass health-related intervention campaigns such as promotion of mass sports, mass campaign for no-smoking, awareness of drug abuse, control of pollution, accident prevention, campaign for anti-alcoholism, etc.

Different modalities have been initiated by Member States for alternative health care financing, such as creating capital and revolving funds, initiating cost-sharing or health insurance schemes, establishing subsidized pay-for-service or health cards for the poor, etc. However, these initiatives are still in the developmental stage and need further review to replicate on a wider scale.

## **2.2 Social Development**

Progressive improvement in living conditions and the quality of life enjoyed by the society and shared by its people that will lead them to an economically productive and socially satisfying life, is the ultimate goal of development. Only when people have an acceptable level of health can individuals, families and communities enjoy the other benefits of life. Based on this concept, initiatives for social development, with health as an integral part, are undertaken in all SEAR countries. These initiatives usually focus on certain areas such as literacy, housing, income generation, employment for poor, etc. The following are a few examples of such large-scale social development which are being used as entry points for community action for health.



The Family Welfare Movement (PKK), a network of women's organizations in Indonesia, extends from the national level to the village level, with the objective of improving the status of women and their families. Health and health-related intervention activities at the community level are usually organized through these women's groups supported by volunteers, in partnership with health workers.

The basic minimum needs (BMN) approach for improving the quality of life has been used in Thailand as part of its national socioeconomic development plan. To bring effective intersectoral action for health at the community level, four major ministries, i.e. Agriculture and Cooperatives, Education, Interior and Public Health, jointly provide support to this strategy. A mechanism has been developed to enable local communities to assess their situation in respect of basic minimum needs indicators, identify problems, discuss possible solutions and prepare their own plans. Solutions which cannot be implemented at the local level by the people themselves are negotiated with the local authorities and technical and financial support is provided.

Poverty alleviation programmes, addressed to urban and rural poor, have been initiated in many countries such as Bangladesh, India, Indonesia, Nepal, Myanmar, Sri Lanka and Thailand. These programmes aim at alleviating the poor from the trap of the vicious circle of poverty, malnutrition, disease and despair that saps their energy, reduces their work capacity and limits their ability to plan for the future. Health is usually put as an integral part of these initiatives. The success of Grameen Bank in Bangladesh has shown women as the most effective point of entry for an improved standard and quality of living. Improved nutritional and health status of the community is seen as a benchmark for further investments. The programme involves the people in a long-learning process through participatory efforts and joint experiences. People gradually build up their own organizational and managerial skills and knowledge, enabling them to foster a sense of solidarity and self confidence.

The Poverty Alleviation programme (Jana Saviya), launched in Sri Lanka since 1989, is another social development initiative. The programme is targeted initially to the poorest of the poor by providing them access to resources so as to initiate income-generating and health development activities. The process is initiated in such a way as to transform them from being mere survivors to prime movers in their own development. Health is an integral component in the Jana Saviya Movement, with priority attention being given to underprivileged children, pregnant women and lactating mothers.

### **3. KEY FACTORS IN PROMOTING COMMUNITY ACTION FOR HEALTH**

From a review of the many examples from SEAR countries, the following important key factors in promoting community action for health emerge:

#### **3.1 Sustaining Political Commitment**

In countries where substantial progress in community action for health is seen, political commitment for involving the people in the frame of equity and social justice is clearly reflected in their national health policies and health programmes. The policy statements are translated into strategies with broad guidelines of action, with adequate resources. In some countries, institutional focal points in community participation are established in the national health management system. Commitment is maintained through regular follow up, monitoring and evaluation. These efforts have contributed to further development of CAH schemes.

#### **3.2 Decentralization**

In most of the countries, appropriate administrative and organizational mechanisms have been established for effective administration and management at the level aimed at accelerating the process of social development. Local community representatives and officials representing different sectors undertake decentralized planning to respond to the local needs. This planning process creates the potential for coordinating inputs of different sectors, maximizing the use of available resources, avoiding duplications and gaps. It is seen that planning and implementation by local-level development committees has generated tremendous impetus for community action. Strengthening the capacity of leadership role of local bodies has resulted in further progress in development. Delegation of financial responsibilities is another fillip to local management capabilities.

#### **3.3 Promoting Leadership Role of Health Care Personnel**

Health care personnel at all levels have either been trained or reoriented on new interventions such as oral rehydration, multi drug therapy, immunization, safe motherhood, and other child survival intervention activities. They are also oriented on how to work with communities. The leadership role of health care personnel is an important function in the success of CAH. Their training provides them with the commitment, advocacy and courage to undertake challenging tasks in harmony with the communities - sharing the knowledge and skills in a partnership pattern.



### **3.4 Enhancing Community Awareness, Organization and Leadership**

Increasing community awareness and creating active and effective mechanisms for community organization have been used and continue to be valid as main strategies of health and social development programmes in the Region. The level of awareness of the community in respect of knowledge, attitude and practices on promotion of health, prevention and care for common health problems, is an important key factor for CAH. Community awareness is linked to the availability of information and the level of literacy, particularly among women who play an important role in health care, to the family and the community.

By 1990, most SEAR countries had achieved adult literacy rates of over 70 per cent, whereas some are still below the global target of 50 per cent. There is also a marked gender literacy gap. With the global Education-for-All initiative, most of the countries have initiated the universal primary enrollment programme and the adult female education campaign. These will have a potential impact on the enhancement of women's status by equipping them with basic knowledge and skills. In most countries, increased efforts are also on to strengthen and improve education for health so that the community is well informed about the interventions and their advantages.

Other means of conveying information on health and health development are also important. Technological advances in communications, increasing availability of communication facilities, such as radio, telephone, television, video machines, satellite TV, speed post, letter publication media, improved means of transport and construction of roads, inter-city mobility, etc., will bring information on health much more readily and rapidly to people, and this will help in improving health and in increasing accessibility to health care.

In this context, the role of NGOs assumes increasing importance, particularly in view of the limitation of governments to cope with the total health needs of the unserved and the underserved population. There are many successful examples of community health programmes in which NGOs and/or other voluntary groups have collaborated with government agencies and the local community by being actively involved in policy formulation, planning, implementation and evaluation of health and health development programmes.

The NGOs function in almost all countries of the Region, and most of them have an independent entity. India has more than 6000 NGOs, and Bangladesh has more than 400 functioning in the health sector alone. Indonesia, Nepal, Sri Lanka and Thailand also have NGOs active in the health sector.



NGOs generally have greater flexibility and freedom to experiment and innovate. NGOs, such as professional and social associations and societies, service institutes, research societies, etc., have a higher degree of technical expertise and accountability. Their service is more geared to assist the decision-making process, rather than to direct involvement in the community action for health. Voluntary NGOs emerge for a social cause and the main aim is to reach the unreached. Their uniqueness, creativity and willingness to work in remote and difficult locations give them more credibility.

They work closely with the community and thus understand the community and adapt themselves easily to the local situation. By involving the community for health action, valuable experience is gained, which greatly enhances their potential for providing services to the underprivileged.

The problems faced by NGOs stem from their individuality, their inclination to adhere to their original objectives, their limited area of functioning and uncertainty of funds, which makes it difficult for them to expand the area of their operation.

### **3.5 Using Multisectoral Approaches**

Often, health development is spoken as being inseparable from national development. In this respect, it is important to examine the occasional conflict of interest between health impacts of ecological and environmental issues on the one hand, and economic development on the other. The survival of the human race itself can be jeopardized from the harmful effects of these ecological and environmental crises, such as pollution, deforestation and rapid industrialization. There is no doubt that industrialization is the key factor for economic development. However, balancing these issues is the real challenge.

The term “health” should not be seen from the negative aspects of the term “disease”. ‘Health service’ is mostly understood as taking care of diseases, which is usually identified as the primary responsibility of the health sector. However, the determinants of diseases such as social, economic, political, environmental, personal behaviour and lifestyle, etc., are beyond the domain of the health sector. Others have to share the responsibility. In the light of the limited resources that can be catered from general public sources, the role of ministries of health is vital in advocating equitable sharing of responsibilities with other sectors as well as the community.

The involvement of all sectors in a joint multisectoral approach for development is more acceptable and attractive for the local population. This could also be observed in such social development schemes where health was an integral part, such as poverty alleviation and income generating schemes.

The trend was also observed in the direction of development of CAH from the purely health initiative to a multisectoral movement. While the multisectoral development approach is extremely important for the promotion of CAH, mechanisms for bringing about different sectors to work jointly are, however, still a challenge in many countries.

## **4. STRATEGIES FOR STRENGTHENING COMMUNITY ACTION FOR HEALTH**

To achieve the universal goal of Health for All in the light of changing and challenging political and socioeconomic environment, all SEAR countries are required to strengthen and mobilize community action for health. The following are some of the most vital strategies:

### **4.1 Sustaining Political Commitment**

It needs to be stressed that sufficient attention should be paid to the implications of changes in the socioeconomic and political arena as well as their consequent effects on health systems. New opportunities, such as the trend for more democratization and decentralization, the shift from drive for pure economic growth to balanced human development with social equity and justice, the trend for restructuring of health systems with concern for cost containment and improved quality and sustainability, etc., which could help strengthen CAH, are opening up in Member States.

All countries are urged to reaffirm their commitment for CAH as a fundamental principle of health development. Sustained commitment should lead to determined action ensuring public policies and strategies and plans of action should be constantly reviewed in the context of political and socioeconomic changes and disease transition. Realistic policies and strategies should be evolved to overcome the impediments and enable the community itself to come forward for greater participation and active involvement.

The capacity of the national health system for supporting CAH needs to be assessed and strengthened with appropriate resources. Concrete strategies and plans of action for health development need to be undertaken to bring about CAH. Monitoring and evaluation based on clear indicators is required as an integral part of broad planning. Priority attention should be diverted for reaching the services to the underprivileged and the acceleration of existing successful approaches and interventions.



## **4.2 Strengthening Community Action for Health within the District Health System**

Within the overall national health system, the district health unit with a well-defined population is an ideal place for developing and supporting CAH. It includes all health institutions and individuals (government, nongovernment and private) providing health care to the district population, together with health-related sectors.

Decentralized decision-making process at the district level, with the involvement of community representatives, has the potential for mobilizing and coordinating local resources for the preparation of local district-specific plans of action. Improvement of management and performance of health care workers at district level is essential for gaining the confidence of the local communities.

It also brings them in close contact with the people in their own environment creating conditions supportive for the development of partnership and stimulating community action for health. In order that district health personnel are adequately equipped to cater to the health needs of the population, it is important that they receive appropriate training.

Most countries have been developing policies and plans of action for the development of appropriate human resources for health, and to enhance the capabilities of health care personnel for initiating and stimulating community action for health. There are still some gaps between policy perceptions and performance. The balance and relevance of human resources for health exist in almost all SEAR countries. The role of health workers has mostly remained affiliated to vertical programmes - either health promotion or disease prevention.

The structures, role and duties of training institutions, including those for the medical profession, need to be reviewed, revised and strengthened with adequate technical expertise and resources, so that their education programmes meet the desired aim of advocacy for health, sensitizing and mobilizing all potential forces in the community, and organizing and supporting communities for action.

Training of health workers, including health volunteers, should be practical and participatory. Field visits for observation and study of innovative approaches within the country should be included in the training. Community-based education should be incorporated in the basic training of all categories of health workers. National training institutes and WHO collaborating centres and NGOs need to be involved in the development of training programmes, including training materials.



### 4.3 Empowering the Community for Action

Empowering the community, enabling itself to take care of its own health needs, is a long-term learning process. Results might not be achieved overnight; however, gains are more lasting and do contribute to overall community development.

An essential prerequisite for sensitizing the community for action is to build awareness of various options for health activities by the community. Health personnel may use various communication methods and channels to disseminate the alternatives. "Awareness creation" deals with the value judgement of the individual as well as of the whole community. Peer pressure for accepting health intervention is more important than interpersonal communication.

The community has to be motivated by showing the positive and negative impacts of various interventions to deal with major health and health-related problems faced by the community. They are also to be shown how to plan, implement and evaluate these through the "learning-by-doing" process.

Sharing and exchange of experiences between the communities alike is also an important step for increasing awareness. The TCDV (Technical Cooperation among Developing Villages) programme of Thailand is trying to achieve such approaches.

In most cases, people in most need, i.e. the poor, women and children, are usually less organized and less vocal. For CAH to be more lasting and productive, and appropriate administrative mechanism and organizational arrangement should be established, ensuring representation by different community groups. It has to be built around the usual networking in the community and not be imposed from outside. The important role of women in health and development needs to be ensured and supported.

Training of community leaders and volunteers on management skill, including enhancement of their leadership role, is required. Health care personnel have to change their usual role of service provider to that of facilitating and advisory role for community efforts and to support them in undertaking collective responsibility for planning and implementing local health initiatives.

It has been recognized that given the commitment and the role of NGOs and other community organizations, there is a crucial need for real partnership between them and the Member States in order to achieve the goal of Health for All. NGOs should be encouraged and supported to sustain their commitment to the implementation of the strategies for HFA and to establish appropriate coordination mechanisms at the grassroots.

Public development programmes, including health, should be so oriented as to encourage the formation of more NGOs and other community organizations. They should exploit as much as possible the positive attributes of NGOs, especially their uniqueness on social cause, creativity and ability to work in hardship conditions.

#### **4.4 Linking with Other Development Sectors**

The development of community action for health is more effective by linking it with broader action for social initiatives in a coordinated effort. This approach is more appropriate as it addresses a wider context of essential basic needs of the community such as water supply, sanitation, health, education, food production, employment, income-generating activities, etc. Health workers have to be aware of the activities being carried out in other sectors in the same locality and elsewhere and be able to identify entry points that can be linked with health action.

Decentralized planning and management of development programmes, including health at the district level, with full involvement of community representatives at all stages, is more likely to bring together linkages for broader social development approaches. National policy and directives should be supportive in strengthening mechanisms for the coordination of sectoral activities for joint actions.

The trend for decentralization in health management with delegation of responsibility and authority from the centre to regions and districts is already widespread in most SEAR countries. This process, which has been taking place in some countries, has made it possible to reshape the existing health information systems leading to better planning and management at the local level. However, a similar process is necessary in other developmental sectors for better results.

## **5. CONCLUSIONS AND RECOMMENDATIONS**

### **5.1 Conclusions**

Even after the implementation of various health policies and plans based on HFA/PHC principles with considerable success, it is realized that there are still some gaps in achieving the health status in different countries and even in different areas within the countries. The experience of countries has shown that only through active involvement of the people and genuine support for CAH will it be possible to achieve the goal of HFA, in the frame of equity and social justice. Keeping this in view and in the light of the above discussions, a number

of possible actions can be suggested with respect to effective community action for health.

## **5.2 Recommendations**

### ***(1) Review and advocacy for HFA and PHC***

In the light of the changing political and socioeconomic scenario and the epidemiological transition prevalent in Member Countries, constant review and advocacy for its continued commitment for Health for All and primary health care is the need of the hour. Priority attention should be paid to health activities targeting the underprivileged population. The policies and directives should also provide an appropriate administrative and organizational mechanism for improving the planning and management capability of the local community.

### ***(2) Improving planning and management capability***

The strengthening of district health systems is essential for improving the planning and managerial capability of local-level health managers enabling them to better manage health activities within limited resources. Towards this endeavour, health care interventions need to be modified to suit local conditions as much as possible, at the same time not losing the quality of health care, in order that the procedures are simplified. Also, it is pertinent that supervisory and support mechanisms within the district health systems are strengthened to improve the performance of integrated health care packages. The establishment of an appropriate information system sustainable at the local level is equally crucial for improving planning and managerial capacity at the district and below.

### ***(3) Undertaking In-depth case studies***

It is felt expedient that in-depth case studies for strengthening CAH need to be undertaken, with particular reference to the emerging areas of concern, such as community organization, alternative sources of health care financing, improvement of local planning and management (including local accountability), and appropriate transfer of technology.

### ***(4) Facilitating effective collaboration with NGOs***

It has been recognized that NGOs and other community organizations have to be in real partnership between them and the Member States in order to achieve the goal of Health For All. Mechanisms facilitating effective collaboration between them should either be established, strengthened or reviewed so that coordinated efforts can accelerate community action for health. Public development programmes, including health, should be so oriented as to



encourage the formation of more NGOs and other community organizations and be able to exploit the positive attributes of NGOs as much as possible.

***(5) A fresh look into new ways of analysing problems***

The present concepts and strategies of PHC and HFA still remain valid. However, a fresh look into new ways of analysing health problem, types of expertise and organizational structures, mechanisms for interacting with other agencies and scale of global actions, is necessary. The support of UN and bilateral donor agencies will enhance the potential of Member Countries in the process of health development.

***(6) Mobilizing international technical and financial assistance***

The mobilization of international technical and financial assistance should be relevant to national health policies and programmes of Member Countries. Coordinated efforts should be made to equip governments with the capability to absorb and assimilate donor-supported activities within their set national developmental aims and activities.

WHO should enhance its leadership role in its advocacy of PHC and HFA concepts and principles. WHO, its Member Countries and the international community should continue to monitor the outcome of the efforts of achieving HFA/2000 and beyond, and be prepared to assist the countries most in need. WHO should coordinate with the international community in facilitating the dissemination of information, exchanging of experience on community action for health in strengthening planning and managerial capabilities, developing appropriate methodologies and implementing health programmes.

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## **Hookworm anaemia remains a major problem**

Hookworm infection and the iron deficiency anaemia it causes are still major public health problems in tropics and subtropics and continue to affect many millions of people. Often, the severity and extent of the problems are not fully appreciated. Because they are most prevalent in rural areas, where health facilities are generally very limited and of poor quality, hookworm infection and anaemia may be under-diagnosed and under-reported; as a consequence, inadequate measures for treatment, control and prevention may be a major factor in the persistence in the community.

In these circumstances, hookworm anaemia may also remain unrecognized as an underlying cause of high maternal morbidity and mortality, apathy and poor health in children, and easy fatiguability and impaired working capacity in adults. Its effects are insidious. Once the relationship is suspected, however, confirmation presents little difficulty and the discovery of iron deficiency anaemia in one area should lead to a search for it in other areas and adequate measures of its control in all sections of the affected community.

— Z. S. Pawlowski, G. A. Schad, & G.J. Stott,  
*Hookworm infection and anaemia: approaches  
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## 2 HEALTH AS A PEOPLE'S MOVEMENT

*P.K.S Madhavan*

AWARE is an acronym for Action for Welfare and Awakening in Rural Environment, a national organization, dedicated exclusively for the upliftment of tribals and harijans. AWARE's activities are spread into six states and in 6000 villages. The major part of its work is located in Andhra Pradesh and Orissa. Other states where AWARE has its outreach projects are Uttar Pradesh, Tamil Nadu, Kerala and Karnataka. There are 1200 full time, 1248 part time staff and 50,000 volunteers working in AWARE.

In Andhra Pradesh, where AWARE was founded in 1975, tribals constitute around 6% of the state's population. The envisioned aura of stress-free life, close to nature, tribals life has invariably to be juxtaposed against grimmer realities. The steep hills with their poor soil and the ever present threat of erosion, the conventional method of cultivation, the lack of agricultural production implements as well as technology, the virtual absence of alternative sources of livelihood, recurrent floods and crop failure, together cause food and income shortages which accentuate want and its debilitating impact on the quality of health and life.

The living conditions of Harijans who constitute 15% of Andhra Pradesh are not at all better to tribals although they live in different geographical situations.

Owing to centuries of social discrimination they are a socio-economic and psychologically submerged and ostracized group who remain have-nots in a very real and brutal sense. Tribals live in isolation whereas harijans are isolated in our society. When AWARE decided to take up the work among these two groups it was fully aware of the complexities of the task it was contemplating and the infinitive challenge it posed.

In AWARE's strategy of total development, health has an integral place. The following describes our experience in health care against the backdrop of its broader intervention.

At the time of inception of the project, the hill tribals were facing deteriorating economic conditions owing to the socio-economic development going on around them, which they were not a part of. Being tribals they traditionally subsisted on forests, living on the produce of shifting cultivation

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and hunting small game. With increasing tribal population and encroachment of the forests by the landlords to convert the forest land into agricultural land, deforestation by vested interests, forest laws prohibiting tribals from living their traditional lives, the tribals, were faced with an extremely difficult situation. A few tribes, owing to their backward conditions and very high maternal and child mortality rates, were already known to be dwindling in numbers.

Malnutrition and increasing poverty was added to this. The life expectancy at birth among them was about 40 years as compared with the average Indian's life expectancy of 54.5. The most important hurdle to their development was addiction to alcohol, particularly among the men, which was almost universal. Alcohol intoxication even during day time prevented any productive work or development. Women worked on the land gathered grain for the family.

In such circumstances, AWARE's programmes sought to create awareness and to empower the tribals and harijans for development. Today it is a continuously expanding project with its target population restricted to tribals of both the hills and the plains and the harijans in the villages covered. Beginning with creation of awareness, AWARE catalyses the socio-economic development needs in the area, as and when these emerge from the people as felt needs. In areas where health has emerged as a felt need, the health programme is started as part of the comprehensive development activities.

The basic strategy of AWARE is to awaken people, to make them identify their own problems and to prepare them to devise their own solutions and plan action. The oppressed must not only recognize that they are oppressed but must also be aware of what they can do legally, peacefully and constructively to overcome their oppression.

### **AWARE's strategy is three-fold:**

- Psycho-social mainstreaming of Harijans and Tribals.
- Higher production directly benefiting these two groups.
- More even distribution of resources for better co-existence of people.

AWARE builds up an organizational system that can function autonomously but at the same time can also interact, interlink and network with other systems and structures in pursuit of the objective of creating self-sustainable rural and tribal societies.

AWARE follows an integrated rural development approach. Awareness building, economic development, employment creation, legal assistance, environmental education, health and building-up of people's organization are

some of its main activities. AWARE does not work in an area for more than 8 to 10 years. In the first three years, AWARE builds up awareness among communities with various social education programmes like community education centres, varieties of training camps, Mahasabhas (Public Meetings), Campaigns, Conferences, Exposure visits, etc. These activities build up communication, solidarity, courage and commitment among these passive communities.

Simultaneously, AWARE promotes people's organizations like Village Associations, Mahila Mandals (women's groups), Youth Associations, Balasanghams (children's groups) in each village. Then 20 village are grouped as a cluster and a Cluster Development Service Society (CDSS) is formed. The annual programme of each village is discussed in CDSS and an annual plan is prepared for a cluster. With the financial assistance provided by AWARE as a revolving fund, and by pooling local resources from Banks, ITDA (Integrated Tribal Development Agency), IRDP (Integrated Rural Development Programme), etc., the CDSS implement economic development and employment generation activities. Services of Trained staff of AWARE, known as cluster development co-ordinator, is provided to CDSS for a period of 5 years. Thus AWARE builds up sustainability of people's movement of development.

AWARE provides interest-free loans for economic activities. AWARE's legal department spreads legal literacy and support with legal back-up services. Environment is also part of the programme. Rural vocational training and disaster and cyclone and flood relief and rehabilitation are part of its work as 1/3 of the AWARE project area is always threatened by either cyclones or floods.

After six to seven years AWARE starts with drawal in a phased manner. By the ninth year AWARE will not extend any financial or managerial assistance to CDSS. By the tenth year the clusters become self-sustaining and completely independent of AWARE. Nevertheless, AWARE maintains links with these independent clusters in its socio-political activities.

So far 2000 villages are independent of AWARE, and not dependent on AWARE's financial or managerial assistance. In 1800 villages not even a single person consumes liquor. These are totally liquor free villages.

## **JEEVANA SRAVANTI**

AWARE looks upon health as a continuous life sustaining force. It is this realization that is behind the health promotive endeavour of AWARE. Its health philosophy is designed by the word "JEEVANA SRAVANTI" which means life's flow.

AWARE did not deliberately impose a preventive bias on any of its health centres' activities. It focused its efforts primarily on curative care which was the felt need of the community and which commands high visibility. Slowly AWARE expanded the scope of its programme to include the preventive aspects as well. For example, recognizing that many of the health complaints in the population were the outcome of unsafe water, creating awareness of the benefits as well as sources of clean water became the focus of preventive action. This led to educational activities on clean water, hygiene and environmental cleanliness. On the other side people agitated for tube wells from the Government. In two years time every village AWARE adopted got tube wells.

Slowly the health centres of AWARE started addressing the key public health problems from curative to preventive. Scabies, pyoderms, herpes, diarrhoea, amoebiasis were some diseases the centres attacked, as these were highly prevalent due to water pollution.

Similarly diseases arising from severe under-nutrition were common to about 90% of children and 37% women suffered from severe anaemia. This led to a series of nutrition camps in the villages with locally grown grains like 'ragi,' etc. A mass programme brought in kitchen gardens, green leafy vegetables. One can find in very house in AWARE adopted villages kitchen gardens, leafy vegetables, beans, cucumber, papaya, almost dominating over the huts in tribal villages.

The practical experience and knowledge gained from treatment and surveys, serves as a useful resource for developing health education and training materials which reflect with the local health context and needs. Health education and training, curative care and diagnostic work thus reinforce each other and are being seen by people as a continuum in AWARE villages. This is peculiar to the project.

There are Community Health Centres (distinct from the government CHCs-editors) located at four places, namely Naidupet, Kunavarm, Padkal and Hinnapuram. These are equipped with twenty beds each, labour room, operation-theatre, and training centre and are expected to function as the base hospitals for the health activities around this area.

The involvement of the medical discipline with the process of development is the crux of the AWARE methodology. Treating people is only one of the Community Health Centre's functions. By disseminating health knowledge, the CHCs must also become "community information centres". Furthermore, by taking an active part in the community development activities, they are expected to serve as "community action centres". This integrated approach permeates the medical functionaries associated with AWARE and affects the



very manner in which the doctors heading the community Health Centres and leading the AWARE health teams conduct themselves.

During a visit, the medical team does not confine itself to health issues. Sitting inside a villager's mud hut or cattle shed, or simply under a shady tree, the visiting doctor may initiate a discussion with the assembled men, women and children. Often the topics discussed are wells, land, school, poultry diseases that are contracted by chickens and finally the health of the community. Watching this interaction, a feeling grows that community medicine is community development. The mystique and aloofness of urban medicine seems to pale in comparison to this dynamic networking of health with life.

A visitor to one of AWARE's Community Health Centres had aptly noted, "Here in these villages, one gets the impression that health care is integrated into the lives of the people and is not treated as a separate entity" and that in a fundamental way "health and life are seen as one".

At all community Health Centres services are provided free of cost. Only a nominal fee is charged for medicines (at cost price); even that is waived in case of deserving and very poor families. The community organization and awareness in the target families is such that most families not only pay for medicines but also contribute towards the maintenance of the Centre. In case of Naidupet CHC having an attached leprosy centre, villages in the surrounding areas contribute for drugs and rehabilitation of leprosy patients.

The CHC at Naidupet focuses on the problem of leprosy. It is not a feeding place for the leprosy affected, or a centre for their free treatment, boarding and lodging. Its emphasis is more on creating an understanding and acceptance of the diseased. Through education, survey, detection, treatment and rehabilitation of leprosy cases and of their families, a receptive, sensitive and constructive climate is created for facing leprosy with knowledge and a sense of responsibility and not compassion alone. In AWARE's terms, rehabilitation does not mean creation of leprosy colonies but restoring patients to their villages and society with the full knowledge, understanding and acceptance by the village.

The reclamation process is in fact based on the acceptance by the village of its joint moral responsibility to take care of every leprosy patient. Enough compassion and a sense of identification have been generated in the villages around Naidupet for them to contribute towards medication costs for treating leprosy and to imbibe and practice the message that the leprosy patient is not to be shunned or renounced.

When the Naidupet Community Health Centre was set up jointly for the treatment of leprosy patients and the general public, initially this effort misfired as the general patients refused to show up for consultation and care. AWARE

then decided to demonstrate its beliefs more openly. It began to host meals cooked by leprosy patients. Public functions were held and festivals were celebrated at the centre where the city fathers and key public figures came and ate the food cooked by cured and non-infectious leprosy patients.

AWARE staff and leprosy patients began to travel together and sat across the table for discussions and for meals. Disfigured but cured leprosy patients were appointed as watchmen, sweepers, washermen, compounders and medical assistants at the centre. Gradually there-after, the general patients started attending the out-patient clinics. Eventually they accepted in-patient care. Soon the Naidupet community Health Centre began conducting minor operations, deliveries and offering other forms of domiciliary care to the general population.

For the able-bodied leprosy patients an agricultural farm was set up on seven acres of land which is now self-sustaining. Sheep rearing, towel making and bandage cloth weaving and other trades are followed, through which leprosy patients have been effectively rehabilitated. In this manner, about 100 patients have become self-reliant. It was rewarding to learn that residents of two AWARE villages invited recovered leprosy patients to settle down in the village. Normal young men and women have also married leprosy victims.

Thus all programmes of AWARE, whether socio-economics or health programmes, are based on creating awareness in the community, creation of a community based cadre of workers and empowering the community. To educate and motivate the community, not only health workers but mahila mandals, youth groups and village elders are involved, reinforcing AWARE's core message that the delivery of health is not an exclusive function of the health professionals.

The training programme of AWARE created a team of health workers from among the illiterate tribal and harijan women and some men. The team of workers include dais, village health workers, paramedical workers. The major thrust of the training is on preventive health care. Mother and child health, nutrition, vaccination and sanitation are the main areas of concentration.

AWARE has built prevention as a fundamental ingredient of its community health programmes in a phased manner, making people realize the need rather than thrusting programmes from outside.

Knowledge (viewed as programme intelligence and not only awareness) has a key role to play at various stages in AWARE's health programme. It precedes the creation of any health programme in that a need has to be specifically felt before any health activity can be launched. Knowledge also figures prominently at the implementation and monitoring stages. AWARE



lays great stress on efficient and reliable health intelligence and control. Detailed health information on the project population is gathered and routinely updated.

A convincing outcome of AWARE's health approach has been attitudinal change in the population it works with.

Within a very short period, tribal and harijan communities have cast off their suspicions of modern medicine and eagerly sought help in upgrading their health status. This change, however, has not meant any disruption of the conventional resources or methods of health care. AWARE deliberately does not discourage use of traditional medicine. It is sensitive to the wealth and wisdom and demonstrated success of reliable primitive remedies.

AWARE has a large network of functionaries at village level, cluster level and even at the area level of carrying out other development activities in the backward areas. There is a large scope to link the activities of all these functionaries with those working for health so that the total welfare of the community can be looked after.

Linkages between health and development and the economics of health are fostered by AWARE in all its operations in various ways.

The Community Health Centres for instance, are encouraged to become economically self-reliant by setting up income generating projects like agriculture, animal rearing or dairying. Income from these helps to defray the cost of running the medical centre.

The health workers are offered similar incentives to become self-reliant. During the initial two years, they receive a small remuneration from the project. This is followed by a loan with which to commence some income generating activity such as poultry or weaving, etc.

We have established a boat hospital along the river Godavari which serves 80 remote tribal villages on both sides of the river. In the rugged Bison Hill range, on either side of the river Godavari, AWARE has a strategy for reaching health care to the Koyas and Konda Reddis - two key tribal groups.

These tribes have been boycotted for decades both psychologically and in terms of service infrastructure. There are no roads nor any other means of easy access through the Bison Hill terrain. The only communication possibility was the mobility offered by the river. We decided to set up a floating hospital in 1984. The government of India and the state government were persuaded by AWARE to finance the cost of a mobile health programme located on a launch. The hospital boat floats on the river everyday. Beginning at 7a.m., it touches five centres on one of the banks each day. The boat has facilities for minor



operations, in - patient care and a laboratory for urgent diagnostic work. There is a doctor on board who is aided by an ANM and a compounder. The crew is efficient and knowledgeable in boat maintenance and repair.

Out-patient services are delivered on the boat, except to the aged and infirm who are unable to come personally. They are visited in their homes by the moving medical team. The tribals come down the slopes to get immunization, first aid, pre-natal and post-natal check-up or general health services.

Routinely, before the out-patient clinic is held, the doctor and his crew climb to the steep hillside to a healthshelter or "outpost" manned by a trained village health worker. Each village also has a trained dai. Here, some of those who live within the jurisdiction of the outpost (8 Villages) gather to chat with the doctor and his team.. AWARE's health and development project staff, leaders of mahila mandals and youth mandals, caste leaders and a mix of women men and children, all sit together to go over any pressing problem in health or other fields. Women speak freely of their difficulties - not only with the lack of medical facilities but with socio-economic programmes.

In all, through 10 outposts, 80 villages of a total population approximating 14,000 are reached by the boat hospital. Bicycles and mopeds are being slowly used to ensure mobility and outreach for the health shelters. The country boats are also provided for each health shelter for transporting patients to the base hospital. The boat teams oversee the health shelters, supervise the dais, village health workers, paramedical workers, and manage the floating health facility and base hospital.

In a period of six years of the AWARE target group, i.e. Scheduled Castes (SC) and Scheduled Tribes (ST) have contributed Rs. 25 lakhs for this health programme. The AWARE Chairman was always welcomed in the villages with garlands. AWARE printed Rs.5/- token ticket and exchanged it for Rs. 5/- instead of garlands. In this manner in six years a sum of Rs. 25 lakhs was collected from the Andhra Pradesh target population alone. Thus every one of Scheduled Caste and Scheduled Tribe families gave their share of Rs.5/- or Rs.10/- towards the Boat Hospital.

In all AWARE Community Health Centres, 60% of the expenditure is pooled locally. AWARE is shortly going to start a cancer hospital at Hyderabad. This is a Rs.15 crores project, and AWARE is expected to pool a local resource of at least Rs.5 crores.

AWARE's achievements in its work with tribals and the harijans are to be measured not only in terms of the number of wells dug or milch animals distributed but in its vision of a tribal and a harijan population that is strongly united, courageous and patient and able to cope with its own requirements and

liabilities through more intelligent use of its own resources and those of the Government.

AWARE's strength arises mainly from its human rights approach to health. AWARE views health as a legal right of the people and not as service or charity rendered unto them. It perceives health as a fundamental duty. People are not only motivated to use a service where it exists, to demand one where it does not but are encouraged and expected to get involved in the development of the health services. AWARE expects them to organize themselves not only to demand the health to which they are entitled, but to ensure that such health is equitably enjoyed by every person in the community.

This approach fits in with AWARE unfolding of people and humanization of personal and group relations.

In AWARE's terms a comprehensive health care programme should make it possible for each individual in the community to attain the highest level of health in a given situation and within available resources.

AWARE believes that health and life are inter-dependent and integrated. Factors that affect the quality of health range from food, shelter, work and education, to general living conditions. All these must develop synergistically for people to become and remain healthy.

There is another kind of desirable synergy, which is between the individual and community. The health of the one is inter - dependent on the health of the other. A successful health programme recognizes how the two impact on each other and therefore creates a basis for individual and collective initiative towards better common health. This is the essence of AWARE's health philosophy.

AWARE's conceptual as well as practical strength lies in rooting health and development functions firmly in people. People's support or accountability for their health are a product of their own understanding or awareness. Creating that awareness is a core function. Once awareness is created the spectrum of health action that follows has to run the entire gamut from prevention and a treatment to health promotive work.

The infrastructure for the delivery of the healthcare has likewise to develop a strong vertical axis running from the base hospital or referral centre to the health centres and subcentres. Health outposts and shelters, community based services and home care.

The human resources deployed for health care should also range from health professionals to paraprofessionals, auxiliary and middle-level workers and those trained from the community to expand health outreach.

By 1992 one of our Community Health Centres at Padkal has been completely taken over by local people's committee known as Area Development Service Society (ADSS) and run with their own income and management. In this manner we wish to realize our aim of health as a people's movement.

AWARE from 1992 extend its programme integrating 12 districts of Andhra Pradesh and Orissa covering two million tribes into integrated rural development programme. Here AWARE is starting 10 Community Health Centres in remote tribal areas. These centres will cover two lakhs population. By 2000 AD almost all centres are expected to reach 80% self sufficiency in its resources. Health becomes a people's movement. AWARE has 39 doctors, 1600 Village Health Workers besides support of two million population. Health should not be an NGO problem or Government problem when health conscious is created then health becomes people's movement.

Women has to take lead in health reconstruction. If women becomes leaders of Health Movement then "People's Health will be in people's Hands". This should be our goal.

### **Essential Public Health Package Includes:**

- ★ The UIP (Universal Immunisation Program)
- ★ Nutritional status monitoring of infants and children and providing nutrient supplementation, including micronutrients
- ★ School health programs to treat worm infection and micronutrient deficiencies and to provide health education.
- ★ Programs to mothers in reproductive age group to improve of their nutritional status by monitoring, supply of nutrients, especially micro nutrients, family formation services including education,
- ★ Programs to reduce consumption of tobacco, alcohol, drugs.
- ★ AIDS prevention programs including Education
- ★ Program to improve living on working Environment



# 3

## COMMUNITY MOBILISATION FOR EFFECTIVE SOCIAL SERVICES

*Mina Swaminathan*

### Introduction

Child care services simultaneously address the needs of working women, young children and their older siblings, especially girls-while providing for the health, safety and satisfactory overall development of young children during the early critical years; they also offer support and freedom from anxiety for the working mother. In India, another dimension is the support for young girls whose education is often neglected because of their household and child caretaking responsibilities. The satisfactory running of child care services is therefore a matter which intimately affects the welfare and development of three very vulnerable sectors of the population.

Tamil Nadu is outstanding in having the most extensive and well-organised infrastructure of child care services in the country. The integrated grid of more than 29,000 centres (including Noon Meal Centres, ICDS and TINP, along with creches in the voluntary sector) offers access to child care to women and children in almost every nook and corner of the State. But how well do these services actually address the intersecting needs of women, children and girls? Studies have shown<sup>1</sup> that there are serious lacunae in terms of both quantity and quality. On the one hand, there is next to universal provision of basic infrastructure in the form of buildings, adequate complement of staff, and a midday meal. On the other hand, the centres are often unsuited to women's needs, either in terms of distance from residence and/or place of work and hence inaccessibility for young children, or in terms of timings unrelated to family work schedules. The programme offered may often go little beyond the midday meal and hardly addresses the developmental needs of children. There is no provision for day-care for infants below the age of two, who most need it. Most significantly, the parents have no say in the running of the centres, and often little interest in them. While parents may often be vocal about the food

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1 Child care Services in Tamil Nadu Mina Swaminathan unpublished 1989  
Child care Services in Tamil Nadu Mina Swaminathan **Economic and Political Weekly**,  
December 28, 1991  
TIMP - Tamil Nadu Integrated Health and Nutrition Project Mina Swaminathan,  
Hony. Director, M.S. Swaminathan Research Foundation 3rd Cross Street,  
Taramani Institutional Area, Madras 600 113.

distribution, this being the concrete and easily recognised and publicized aspect of the programme, the tendency is to accept whatever else is offered, since it is seen as free hand-out by the State rather than to critically assess the services and demand effectiveness. As a result, a heavily centralized and impersonal administration is unable to make the services responsive to the varying needs of the community of women, children and girls in different situations.

- In this setting, it seemed that the most economical and effective intervention strategy would be to attempt to bring “demand” and “supply” together, rather than to attempt to set up wasteful parallel systems to meet needs. The “alternative” envisaged here is a process-oriented approach, and not an alternative system. The approach can be described in terms of creating an informed “demand” which will oblige the “supply” to modify itself. This was sought to be done by the process of mobilizing parents and community, especially the mothers of the children in an action-research programme taken up by ACCESS (1991-93 ongoing) which provided the experience on which this paper is based.

## **The Objectives**

1. To explore ways and means of making the system of State child care services more flexible and responsive to the needs of women, young children and girls and
2. To achieve the above through a process of mobilizing and involving parents and local community in monitoring, guiding and managing child care services

## **The process**

**Initial survey:** The first step was identifying and assessing the child care needs of women working in different occupational niches. The groups chosen for study were women workers in small-scale industry, agricultural labourers and small peasants and fisherwomen. (Quarry workers, construction workers, domestic workers and urban vendors are being taken up in the next phase.) Women studied in some villages of Kattankulathur block of Chengai-Anna district were found to fall into four major occupational strata-agricultural labourers, small peasants, non-working housewives and others. Caste-wise differences were also observed among Villiyars (tribals,) Scheduled Castes, backward castes and dominant castes. Each of these strata and caste groups have different positions with respect to access to available facilities and the degree of involvement in decision-making in relation to them. While the



services are meant to reach the most vulnerable segments, in practice they often cannot be availed of them, or the programmes are not effective enough to make any impact. Hence it was felt necessary to start working by identifying and mobilizing the most affected persons, that is, the mothers of young children, especially the working mothers, who are often in terms of age, caste, class, gender, and social position the least powerful persons in the community.

**Self-financed creches** In the early stages of the programme women's groups were formed in two villages with the express purpose of running self-financed creches to serve the needs of the most needy sections. The creches were in fact run for several months without any outside resources, by local teenage girls with some training and supervision. However, given the financial status of the group and the existence of free State-run child care centres in all the surrounding communities, it was but natural that this experiment was short-lived. Its real value lay in giving the women an insight into the purpose and function of child care services, and self-confidence arising out of an appreciation of their own abilities and skills in managing a programme, along with the understanding of how to go about solving their own problems. Thus, while the creches could not continue for long, a real step forward had been taken in the process of empowerment.<sup>2</sup>

**Intervention with teachers** At the same time, work was also started in a cluster of five villages where existing ICDS services were well established. A series of meetings was held with the teachers of these centres, with the support and encouragement of the supervisory staff. The objective was to see in what way training or detailed support could be offered to teachers to help improve the quality of programme. However, what was observed was that the teachers were wary and suspicious, if not downright resentful. They have been subjected to many short-term "training's" and consider these, as well as the demands placed on them, to be burdensome. This is not surprising in view of the low remuneration and status they enjoy for which they are expected to put in an unprecedented amount of time and hard work. The exercise dragged on for several months but little progress seemed to be made. It became clear that some changed strategy would have thought of.

**Intervening with parents** The next step was direct intervention with the parents. With the help of a community organiser residing in the area, the parents were contacted individually and in small groups and their view elicited. At the same time the village sites were explored, facilities noted, and profiles drawn up after simple surveys of need were made. The first workshop was organised,

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2 Second Annual Report 1991-92 M.S.Swaminathan Research Foundation, Madras



with three to five women from each of the five villages, to identify problems in relation to child care services in their area and begin to suggest solutions. From the beginning, the teachers were also involved in these workshops, playing an advisory role, recording conclusions and later following up on actions. However, the barriers between teachers and parents were very obvious, especially at this first meeting, and special techniques like games and music were used to break these down and build up an atmosphere of trust and mutual respect without which cooperation would be impossible.

**The pattern of mobilization** In the next few months, a pattern of activity was developed. After a series of preparatory meetings and discussions with women individually and in small groups, a joint workshop would be held on a chosen theme. This in turn would be followed by various follow-up actions by parents and teachers, with the coordination of the community organiser. This pattern of intervention was later crystallised into a module of empowering and training of parents<sup>3</sup>

**Training Strategies** The second workshop in the series deserves special mention for its methodology.<sup>4</sup> Aimed to enable parents to understand the basics of child development and the role of play in the child's education, and hence in the well-organised child care centre, the entire workshop was planned as a play experience, using low-cost indigenous materials easily available in rural areas. Focus was on natural materials such as sand, water, clay and agricultural products and waste, as well as household objects and things easily purchased in local shops. Periods of "hands-on" experience of play materials and play activity of different types were followed by periods of reflection through group discussion. This proved to be not only a stimulating experience leading to valuable insights and conclusions about the nature and value of play in child development, but also proved to be the key to breaking the barriers between teachers and parents. After this shared and joyful plays experience, and the dawning realisation that they could work together for common goals, attitudes unfroze and the relationship between the two groups began to change dramatically.

The first assignments given to the group were in terms of improving the infrastructure, building up the stock of play materials for children's use through parental effort.

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3 An Intervention - Training Module for Developing Women's Skills for monitoring and Managing Child Care Centres Project ACCESS, M.S.Swaminathan Research Foundation, Madras

4 Learning through Play Video documentation of a workshop. 23 minutes Project ACCESS M.S. Swaminathan Research Foundation, and Communication and Training Centre, TINP Govt. of Tamil Nadu Madras 1992

**Criteria for monitoring** The third workshop proceeded to look more closely and critically at the child care centres and to ask questions about how to assess its effectiveness. Through structured discussions, role plays and visual aids, the various domains of child development and the requirements to attain each objective were spelt out. Criteria began to emerge, as well as indicators: what should one look for in a child care centre? what should it have? what should the teacher do? how can we tell if the objectives are being achieved? The answers were spelt out in simple terms and then recorded through media like songs.

**Participating in management** The next exercise was to consider actual problems that had emerged and brainstorm for ways to solve them. Some of the problems taken up were—lack of a safe structure, teacher absence or irregularity, poor and non-nutritious food, unsuitable timings. In each case, the outcomes of which are described in the next section.

The last workshop in the series was review—spanning concrete achievements and skills gained in the year, problems faced and tasks remaining to be done. All the workshops were of an informal and highly participatory nature, using devices like games, songs, role plays, art and craft and group discussions, and evolving complex concepts and actions plans in a dialogic manner. However, even more important was the constant interaction and support offered by the field worker for the actions planned and carried out by the women's groups as recorded in the module.

## The outcomes

The outcomes can be classified under three heads—concrete,<sup>5</sup> attitudinal and methodological.

**Concrete achievements** Some of the concrete achievements of the parents groups in improving child care services are the following.

1. Infrastructure— By repeated visits, petitions and dialogue with the authorities, parent groups were able to

- get repairs done to the roof and buildings in instances where this had been neglected for several years.

- speed up the sanction for a new building and have it constructed and opened

- Change the location of a child care centre from a site where very few of the children has access to it, to a different housing area where the maximum

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5 Third Annual Report 1992-93 M.S. Swaminathan Research Foundation, Madras

number of children would be benefited. Approval for a new building in this area has also been obtained and the construction is under way

2. Teacher behaviour By close monitoring and regular visits to the centre, pressure on the administration, direct contact with the teacher support for the teacher in solving her personal problems, the parent groups were able to

- improve the regularity of attendance of the teacher in one case, where the teacher was notoriously irregular

- make all the teachers in the group more attentive to children, interested in their work and active in carrying out play and educational activities and attending to children's needs

- in another case, the parents continue to insist that the present teacher must be transferred as they are unable to bring about any improvements after much effort

### 3 Participation in educational activity

Through a combination of workshops, shramdan, paid labour and pressure on the administration, the parent groups have

- prepared low-cost play material for children from locally available materials. Some of these were also displayed at an exhibition jointly organised by some of the parents groups. Teachers are regularly making use of these materials

- got the playground in one child care centre fenced and started leveling the ground and fixing some low-cost outdoor play equipment for the children with locally available materials

4 Nutrition: As a result of increased awareness about sources of nutrition and the nutritionally poor quality of the noon meal, parents started occasionally donating some vegetables for the midday meal and now plan to start and maintain kitchen gardens in the child care centres.

5 Day-care: In one village where the mothers are all agricultural labourers and return late from work in the evenings, the need was felt to lengthen the working hours of the child care centre, and the helper was asked to work for two hours extra in the afternoons. In return the mothers made a small monthly collection to recompense her. In another village, a similar informal arrangement was made to provide an incentive for the helper to escort the children home from the child care centre, which is far away from the residential area and has some hazardous points along the way.

6 Management: In one village where some members of the women's group have keen interest in the child care centres and can spare the time, a roster of mother and teen-age girl volunteers has been made, to provide help in running



the centre when the teacher is absent in an emergency or when she suddenly is called to the administrative headquarters, as happens frequently

These arrangements, some still in the experimental stage, other one-time or short-term efforts, illustrate the kind of actions taken by the mothers' groups

2. Attitudinal changes: Of even greater significance than the concrete achievements which may seem small, are the observed changes in attitudes of parents, teachers, administration and the community, some of which are listed below.

### **Among parents**

Awareness about the role of the child care centre and its potential, created by regular monitoring, and attendance at meetings and workshops

- ability to identify issues, discuss them collectively, and arrive at practicable solutions to problems
- sense of confidence arising from their ability to change things by their own actions and from their understanding of how and why things function as they do
- understanding of how to negotiate with authorities
- a sense of "ownership" of the child care centers, a feeling that it belongs to them and their children and that they can change it if they wish
- a greater understanding of the role of the teacher and appreciation of her difficulties and problems

These are indicated by the nature and regularity of participation in workshops, the ideas articulated at the meetings, and the ability of the group to work together in a sustained manner to achieve concrete outcomes listed in the previous section

### **Among teachers:**

- closer identification with the job and its objectives and greater interest in their work, indicated by reduced pilferage, more regular attendance, and organised activity in the classroom
- closer and more friendly relations with the parents, indicated by their willingness to work with parents to achieve concrete outcomes. The sense of hostility and the feeling that they were being critically watched by parents for their performance is gradually being reduced

### **Among both parents and teachers**

- greater trust, mutual respect and cooperation
- in the administration

- speedier response to requests from the community
- greater willingness to talk to the community about proposals and to negotiate with them

## **2. Methodological insights:**

There are several useful methodological lessons to be learnt by those planning such interventions for community mobilisation.

- the regularity and frequency of monitoring is an essential element for success. In the first year, this was provided by the resident community organiser. In the second year, the model followed has been altered slightly. Monitoring is now carried out directly by the women's groups situated in each of the twelve new villages taken up. It is yet to be seen how effective this model will be

- Process-based intervention emphasising attitude change, organisation, and skill development for leadership is another important element. This methodology can equally well be applied to monitoring and management of other services in the social sector, such as health service or primary education.

- development of a training module for parents was another important outcome. The module is available to other agencies wishing to take up similar programmes of community mobilisation for improvement of social services.

## **Emerging theoretical issues:**

The question may now be raised: how far can community participation and parent involvement go in improving the effectiveness of State-run social services? Is it possible at all? Can local monitoring play a role? How much outside intervention is needed as support? The experiment in grassroots mobilisation described above brings up several theoretical problems and issues which will have to be confronted and resolved if such mobilisation is to be effective.

**Priorities and powerstructures** Caste, class and gender significantly affect the priority given to child care services by the community. Child care services run by the State cater to and are intended for the poorest segments, and are thus not of much interest to the better off and more powerful sections of the community. This is one reason why in many communities, local leaders and women's groups whose membership is drawn from the better off sections, have taken little interest in child care centres so far.

Caste plays a role in two ways— the working mothers in rural areas generally belong to the lowest castes and thus again have little place in the village power structure. Further, the SC residential areas are usually at a

distance from the main village, where often the child care centres tends to be located, so geographical distance also plays a part in poor utilisation of facilities, lack of interest among residents of the main village, and a sense of powerlessness among the SC community.

Again, child care is most significant for women, who are not at the top of the hierarchy in an essentially male-dominated power structure. The women, especially those belonging to the poorest and lowest castes, are least able to articulate their demands and needs or to work to get them met. They have less experience of being listened to.

Then there is the question of age. Many of the working mothers of young children, the group most in need of child care, are also likely to be the youngest in the community, and hence least likely to be listened to within the family and the community.

And finally, the transience of the parent group for child care. At any given time, the number of women in the community with young children, for whom child care is an important issue, may be few. Of course, new young mothers join the group every year, but others whose children have grown up, may lose interest in the issues. Thus the group is a changing one, and continuity of interest cannot be expected. This may have both advantages and disadvantages but it implies that the process of inducting, enthusing, motivating, consciousness-raising, etc. has to be constant and continuous.

All of these factors contribute to making child care a low priority issue, not likely to be taken seriously or battled for, unlike issues such as drinking water, irrigation, income-generating activity etc. In organising groups to work at tackling social services, therefore, one has to realise that this is a “soft” or “weak” issue and evolve strategies accordingly.

**Organisation of Groups** Identifying women’s groups which will work steadfastly at this issue, or organising one to do so, is also difficult for the reasons already explained. A group formed entirely of working mothers of young children may be a very weak one. The mothers are often too busy and exhausted, have little time and few skills, and little or no say in the community.

They are afraid to voice their problems, and even if they do may not get listened to. They may not have the time to pursue the type of actions needed. Thus to tackle the ‘soft’ issue, it may be necessary to ride with another more powerful group.

On the other hand, the regular women’s group in the village, it was found by observation, often consists of women of slightly higher caste and class and often had little knowledge and no interest in the problems of child care. In these



groups, it was found that older women., who have more time to spare for such activities, were dominant, and their interests were different. In the stratified rural society, it may be difficult to bring the two groups together on this issue.

Building the child care component into a group already formed for economic purposes, such as a union, a cooperative, or an income-generating activity is another possibility but this has not yet been tried out. Child care has to be perceived as important by these more powerful groups before it is taken up as an issue.

Another example of a weak group is that of the Villiyars and Irulas, or semi-nomadic tribals found in Chingleput district. Isolated, living in small clusters far from the main village, at the margin of poverty and usually working for long hours on the people's fields and in the forests, they are almost invisible to the administration and easily fall through the net of social services. Hardly any of them have their children in any of the child care centres. They are also most difficult to reach or organise, and their interests do not coincide with that of the women's groups in the main villages, to whose members they are often invisible.

**Decentralised management** The efforts of women's/parents' groups to influence and be involved in the management of child care services also raises some critical issues concerning decentralised management— how, by whom and for whom should the service be managed? In the absence of an effective local government to handle and resolve local issues, mothers and community today are at the mercy of an impersonal, centralised and distant administration which responds very slowly, if at all, and with cracking joints, to local pressures and which is sufficiently insulated not to care about responding.

At present, however, there are no elected local bodies in Tamil Nadu and therefore, power is locally wielded informally by various groups, including traditional village elders and headmen, caste leaders, and local political party cadres. Many of these people may be benevolent and with intention to develop good social services in the villages, but their perception of the problem and its solution are very different from that of the women most concerned. Without organised representative bodies like Panchayats to deal with the issue, apathy, indifference, political pressures and vested interests may block women's legitimate attempts to secure adequate and appropriate child care services.

There is hence a strong case for decentralised management of child care services by local governments, supported by bodies like parent groups and /or women's groups which can act as effective monitors and links between the management and the public. In fact, all social services should be managed by local bodies in which women are strongly represented, and this is in fact exactly

what is intended by the recent 73rd and 74th amendments to the Constitution, which places the issue of “women and child development squarely in the lap of the local administration, and which also provides 30% reservation for women in Panchayats and local bodies. However, these arrangements are still in the future, and as Tamil Nadu has yet to ratify the Amendments, it may take some time for them to become effective.

**Politics of social welfare** The universal Noon Meals Programme in Tamil Nadu, which is the bedrock on which the entire child care system rests, was started essentially as a populist political measure at the outset, though other elements have subsequently been built into it. As noted in the previous paragraph, child care services may have low priority in the context of the local power structures, but form at the same time a highly politicised and vulnerable section of the administration. Appointments and transfers of staff, contracts for supply and transport of food, buildings and equipment are all potentially lucrative and distributed through political patronage, providing opportunities for leakage and misuse at various levels. In this situation, women’s groups, especially authentic parent groups, may find themselves up against another power structure. A simple illustration is the case of a highly unsatisfactory teacher whom the entire community would like to get rid of, but who has sufficient political support to be untouchable— she can neither be transferred nor fired! Here again the answer must be sought in the direction of legally elected representative bodies at the local level, which will have to concern themselves with the interests of all categories of people, including poor working mothers of young children.

**Populism and public perceptions** Populist welfare measures, of which the Noon Meals scheme is the grandest and most elaborate, form an integral part of the political philosophy and style of the two leading parties in the State. While the scheme is high prestige and high profile in nature, and often mentioned as the base of the popular electoral support, the extent of real community participation is minimal. Even the early attempts to get free accommodation, free fuel and vegetables from the community were given up fairly soon, and it is now expected that all the facilities will be provided free by the State. There is little motivation for contributions, either in cash or kind. On the contrary, it is expected that more and more will be provided by the State, and unwillingness to take up any responsibility beyond providing land for the child care centre. The general mood resulting from years of “dole” ranges from apathy to expectation to demand. This is not a climate which encourages critical assessment of services, moves towards self-reliance, or active involvement in improvement.

The public perception of the service is that of a food hand-out and not of day-care, though the latter component is formally a part the scheme now. So the whole idea that the programme is intended to offer day-care for the children of working mothers is a strange and novel one to public, and the idea of struggling to make it functional and responsive may take time to take root. It is therefore possible that it may be easier to bring about such changes in the case of health services or primary education where no such preconception exists. Child care may in fact be the area where it is most difficult to get community participation, precisely because it is seen as the area of Government largess. But when people begin to question the way child care services are run, as they have done here, they may soon begin to question the way health services or primary education or any other service is run. This could well be the beginning of a new kind of community mobilisation and participation in the management of social services.

The health sector receives a pittance of government resources. The distribution of these resources between primary, secondary, and tertiary care is irrational. We need to increase the proportion of funds devoted to primary health care and, within primary health care, the proportion dedicated to maternal health. Once funds reach the maternal health/primary health care level, fiscal management is extremely poor, reducing the potential return on already limited funds. Our chances for multiplying health sector resources are bleak. We could double the impact of the resources we have now if they were rationally allocated and properly managed.

*-Dr. Harcharan Singh*



# 4

## PEOPLE'S PARTICIPATION IN WOMEN WELFARE ACTIVITIES IN URBAN AREAS.

*Mrs Rachel Chatterjee I.A.S.*

It is a universally accepted notion that people's participation in development is of paramount importance in the development of a country. It logically stems from the fact that unless people make a concerted drive towards the desire goal, that achievement will be of very low order.

The subject of people's participation raises four main issues.

- What is participation?
- Why is participation necessary?
- Problems of participation? and
- Strategies of Participation?.

These four issues upon examination suggest the following conclusions:

Participation is the total involvement of the people as a complete unit in schemes regarding their lives, environment and future.

Participation of the people is necessary because it requires their total involvement with the development process. Successful programmes by voluntary organisations have been marked by the total and unswerving participation of the people of the target group.

**Problems of participation:** The various problems and obstacles that lie in the way of peoples participation are :-

- 1) Illiteracy and Ignorance
- 2) Taboos, conservatism and religious dogma
- 3) Heterogenity in small communities
- 4) Economic dependency and exploitation
- 5) Pessimism and Apathy
- 6) Centralised planning system and vested interests
- 7) Political and administrative exploitation
- 8) Failure of the people's institutions and resulting disenchantment
- 9) Neglect of women's sector
- 10) Lack of awareness of rights and duties.

The entire problem stems from the total lack of knowledge of issues relevant to the people. Illiteracy does not mean the inability of the people to read and write. It refers to the lack of knowledge of their rights and duties and failure

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of the Government agencies to implement a system of People's education that engenders in them a comprehensive knowledge that is relevant and significant to them. Similarly taboos, conservatism and religious dogmas will be obliterated by an enlightened education system. In addition once they have been made aware of their rights and duties, the problems of heterogeneity, economic dependency and consequent exploitation, apathy, will be, to a great extent, mitigated.

**Strategies:-** Various problems of participation can be solved by the following methods:

- A) The formulation of a comprehensive need-based education system.
- B) Dedicated action by the voluntary organisations to restore the confidence of the people in the credibility of these institutions/organisations.
- C) A decentralised planning system which would encourage the people themselves to formulate plans for their development.
- D) To take up the women sector on a priority basis, and make them enter the main stream of the development process.

— Education in its meaning has to include:

- A) Civic education B) Literacy and its follow-up C) education for economic improvement D) Education in health and sanitation E) Healthy forms of recreation, cultural programmes etc.

— Voluntary organisations must play a more responsible role than they have hitherto been doing. Many such organisations have ventured into the field only to benefit. People have now begun to be very wary of any agency entering their ambit and a genuinely dedicated agency will often meet with indifference and disdain. The agency work will be insurmountably difficult. To combat this, there is need for dedication on the part of the development agencies, both from Government and Voluntary organisations to restore confidence.

— A decentralised planning system is an immediate need in our development system. To collect a random set of statistics and universally apply them for the development plan will be self-defeating in character. If area-wise plans are made with a bottom-up approach, the participating communities themselves who are the best judges of what their needs are, would ensure practical, need-based plans. The Government should monitor all such adopted plans at much less cost than it incurs at present in implementing centrally administered and centrally conceived plans. Locally available leadership should be encouraged at all levels to give the required boost to people's participation at all stages.

— Existing people's institutions have to be revitalized and rehumanised. Many of them while conceived in good faith have become such large and

cumbersome bureaucratic behemoths that they cease to have any relevance to the people. Such Institutions be re-oriented and re-established to be truly participatory in nature, voice, and deed. This can be done if only they are re-constituted and made a part of the people, rather than an unbending edifice of bureaucratic red tapism and indifference. The watchword at all times must be to encourage rather than to suppress the co-operative effort.

## **WOMEN, DEVELOPMENT, PARTICIPATION AND URBAN ENVIRONMENT:**

The notion of integrating women into the development process has in the past few years become a catch phrase in development jargon. But for millions of women in the developing countries that process has just not begun.

Hitherto the women's sector has been almost totally forgotten in the bid to encourage people's participation. Only recently have women been given some importance in the sphere of health and family welfare. It is about time that women are given their rightful place in community participation. Whereas women form 50% of the adult population, only in a few isolated pockets of the country have they any say in the development process. Usually when community meetings are held, women have no say in the matters concerning them. Both men and women must be educated to perceive the folly of this view. Women should be the main force in the stream of development since they are responsible to the community as a whole for the future generation. Once the active participation of women is established, the community can and will be a cohesive and ideally representative unit.

The Municipal Corporation of Hyderabad is implementing an Urban Community Development programme which is otherwise popularly known as a "people's Programme". All welfare programmes which aim at the development and betterment of the down-trodden communities and weaker sections residing in the slum areas are implemented through the Urban Community Development Department in the twin cities of Hyderabad and Secunderabad. The basic approach of the Urban Community Development is to organise the communities on neighbourhood basis by forming them into non-political welfare organisations like the Neighbourhood Committees, Mahila Mandals, Youth Organisations, Interest groups etc. The representatives of these organisations are trained in the development process and their role in community participation. All the welfare programmes are introduced through the active involvement of these organisations in the slum areas by ensuring people's participation to the desired levels. This unique feature has shown successful results.



Some of the women development programmes implemented in the Hyderabad city are detailed below:

**Women in Hyderabad - A Study:-** In Hyderabad city, number of schemes/projects are functioning for the development of women and children, and that too, with their active participation.

**1) Anganwadies and Creches:-** These institutions are run by the Women and Child Welfare Department, Government of Andhra Pradesh. These centres are run mostly by women and they are rendering great services.

**2) Balwadies :-** These centres are located in slum communities in twin cities and are run by women for the benefit of children of that area. These are assisted and supported by U.C.D./O.D.A. of the Municipal Corporation of Hyderabad.

**3) Tailoring and Craft Classes:-** In order to satisfy the needs of the younger members who seek higher skilled occupations than the vegetable or flower vending of their mothers, U.C.D./O.D.A. of M.C.H. has been running number of sewing centres/ craft centres/ Type-writing centres for the benefit of women in twin cities.

**4) Non-formal education centres:-** Non-formal education centres are working under the direct control of the Hyderabad District Educational Officer, These centres cater to the needs of the women and children residing nearby and are staffed mainly by women teachers.

**5) Mahila Mandals get-togethers :-** These are organised with the objectives : a) to facilitate the exchange of ideas' and experience of different mahila mandals b) to focus the attention of all the concerned on the problems of Mahila Mandals c) to actively involve Official and Non- Official bodies in implementing the future programmes in the project areas.

In these get-togethers, matters relating to organisation, programmes and activities, education and training, accommodation and finance are discussed. These get-togethers end with cultural programmes. These are organised by U.C.D./O.D.A. of the M.C.H.

**6) Children rallies :-** Every year on 14th November, children rallies are organised by U.C.D./O.D.A. of the M.C.H. for the benefit of children. Games/ Sports/Cultural events are organised for the benefit of children.

**7) S.N.P. Programme:-** Special Nutrition programme is carried on by U.S.D M.C.H. in about 300 centres for the benefit of Women and Children and pregnant and lactating women. Food is given free of cost in all these centres.

To equip the women in low income group range about the availability of nutritious and palatable food, S.N.P. training programmes are organised in

collaboration with UNICEF by U.C.D. M.C.H. Experts have demonstrated both theoretically and practically about such programmes. Food demonstration are very frequently held in the slums by U.C.D. in collaboration with Department of Food and Nutrition, Government of India.

**8) Neighbourhood Committees:-** Neighbourhood Committees are constituted mostly encouraging women on their role. These committees are doing yeomen service for the society, by way of programmes- tree plantations, Akshara Joythi, Sanitation- Health check camps etc. etc. programmes. .

**9) Income generating activity for women :-** A.P. State Women's Co-operative Finance Corporation Hyderabad, offers seed money for Women's self-employment projects and helps women with identification of viable projects, drawing up project profiles and marketing.

Under Nehru Rozgar Yojana programme 30% of the assistance is extended to women beneficiaries to support themselves to stand on their foot. This is being done by U.C.D./M.C.H.

**10) Social Welfare Activity for Women :-** Andhra Pradesh Government has established Rescue Homes/Short Stay Homes/ Old-Age Homes for the needy persons in these institutions in Hyderabad.

**11) Mother-leaders Training programmes:-** Are organised by U.C.D./O.D.A./M.C.H. with financial assistance of UNICEF. In these one-day programmes, various issues dealing with leadership are taught to them.

**12) Health Programmes for Women and Children :-** Maternal and child health services are carried on in a big way to reduce infant and maternal mortality rates in Hyderabad by M.C.H.

**13) Training programmes for women:-** Apart from training programmes conducted for skill formation/upgradation by U.C.D. M.C.H, women are also got trained by two Sharmik Vidyapeeths, Hyderabad- Ranga Reddy Districts which are headed by Women Directors only. These two Shramik Vidyapeeths are conducting short/long duration courses that are beneficial to women.

In sickness and in health women tend to suffer more from the consequences of the maldistribution of wealth and services. The global inequality perpetuated by the present economic system contributes to a dynamic process linking Socio-Economic sectors. Preventive measures of a political, economic and Social kind are needed in order to combat this situation, and present more coherent strategy for development of the women's sector. A development strategy which caters better for women will only come about when voices of and for women and on behalf of women are heard more loudly at policy and decision-making levels.

People's participation is of paramount importance in the field of development, without which any plan conceived either at the local or central level will be disenchanting and therefore self-defeating.

**Immunization.** In 1977 the WHO Expanded Program on Immunization (EPI) established the objective of immunizing all children throughout the world against six major childhood diseases—diphtheria, pertussis (whooping cough), tetanus, measles, polio, and tuberculosis. An international campaign, led by the United Nations Children's Fund (UNICEF), sought to immunize at least 80% of the world's children against these diseases by 1990. Starting from birth immunization includes a BCG vaccination (against tuberculosis), a measles vaccination, three doses of DPT (diphtheria, pertussis, tetanus) vaccine, and three doses of polio vaccine.

Immunization levels have risen dramatically, according to the DHS, but the goal of universal immunization is still far from achieved.



# 5 COMMUNITY PARTICIPATION IN MATERNAL AND CHILD HEALTH AND FAMILY WELFARE SERVICES - A METHODOLOGY EXPERIMENTED AT VADAMADURAI BLOCK - TAMIL NADU

*P, Sivagnanam*

**INTRODUCTION** Community participation has been recognised as the principal strength and support of Primary Health Care. World Health Organisation defines community participation as the process by which individuals and families assume responsibilities for their own health and welfare and for those of the community and develop the capacity to contribute to their community's development.

Since 1959, the Gandhigram Institute of Rural Health and Family Welfare Trust has demonstrated the importance of community participation in the promotion of health and family welfare programmes. To list a few, the leadership approach in Athoor Experience, Integrated Development Project for improved Rural Health at Athoor Block, District Development Demonstration Project in Anna District, Integrated co-ordinated Multisectoral Project at Guziliamparai, Research on Health Survey Technique at Melur, and the International Development Research Centre, Canada project for improving Sanitation through community participation at Chinnalapatti. Similar such attempts were made by the National Institute of Health and Family welfare, New Delhi; Rural Unit for Health and Social Welfare Affairs at Vellore in Tamil Nadu and others in the country. Though several projects have been initiated in different spheres of health and development in order to translate the principles of community participation into a replicable strategy, much remains to be done for sustained community participation that can put the existing health and family welfare infrastructure into optimal utilisation.

Therefore a project was undertaken by the Gandhigram Institute of Rural Health and Family Welfare Trust at Vadamadurai Block of Dindigul Anna district, Tamil Nadu during the period 1988-1991 with financial assistance

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from the National Institute of Health & Family Welfare, New Delhi. This paper explains the methodology adopted in this project titled - “ An Action Research to Develop a Methodology for Community Participation to promote Maternal and Child Health and Family Welfare Services Acceptance”.

**RATIONALE:** The main thrusts of this project were in terms of community mobilisation, developing inter-sectoral linkages at sub-centre level, and ensuring the availability of Maternal and Child Health and Family Welfare service at the sub-centre level. In Tamil Nadu the existing infrastructure does not incorporate the concept of Health Guide Scheme and even the ICDS programme is not operating in many areas. This project attempts to provide integrated services - health services, village health guide services and community mobilisation services.

**OBJECTIVE OF THE PROJECT:** “To evolve a methodology of community participation in maternal and child health and family welfare programmes by utilising the available infrastructure in the government health set up with additional input of community’s active involvement through a systematic approach”.

**PROJECT AREA:** Vadamadurai block - one of the 14 community development blocks in Dindigul Anna District of Tamil Nadu was selected for the project based on low performance under maternal and child health, immunisation and family planning acceptance (source: District Health Office records).

There are three primary health centres viz., Vadamadurai, Ayyalur and Pilathu functioning in Vadamadurai block and Vadamadurai is the main primary health centre for this block catering to 37946 population. A contiguous area comprising of 5 Health Sub-Centres (HSC) ( out of 7 HSCs in Vadamadurai primary health centre ) viz., Kulathur, Padiyoor, Velvarkottai, Kanapady and Velayundhampalayam, covering 25326 population spread over 70 villages formed the project area.

**COMMUNITY PARTICIPATION IN THE PROJECT AREA DURING THE PRE-PROJECT PERIOD:** Adopting socio-metric method, 182 influential leaders were identified in the 70 villages of the project area and an informal interview was conducted with each of them by the project officer to assess the existing areas of community participation and involvement. 64.8% leaders have expressed that there is community participation in conducting festival celebrations in their villages. Another 57.7% have told that community participates as and when they need to mobilise water sources. Arranging street lights, temple construction, procuring TV/Radio sets for the village, procuring loan from banks/cooperative societies, sometimes on the village sanitation and



in notification of epidemic diseases were reported by around 15-25%. Spontaneous profile reveals that community participation in the areas of health, maternal and child health and family welfare activities were not existing during the pre project period.

**PROJECT PHASING AND ACTIVITIES CARRIED OUT UNDER EACH PHASE:** The total duration of the project was for three years and carried out in three phases. Phase I of the project was the diagnostic phase for five months, phase II was the action phase for twenty four months and phase III was the evaluation phase for seven months.

**METHODOLOGY:** The methodology to initiate community participation involved a systematic approach of working through specific groups in the community and ensure their sustained participation for utilising the maternal and child health and family welfare services (MCH&FW) already available with the health infrastructure.

The methodology followed during the action phase comprised the following components / activities described in the following paragraph 1 to 9.

**1. Health personnel orientation and involvement:** the formal sanction of the governmental health authority was obtained to utilise the five HSC areas of the Vadamadurai Primary Health Centre (PHC) for experimenting this action research methodology. Thereafter the district health officials and the personnel at the PHC, the sector and the grass-root level workers were met many times and oriented individually and in groups about the project, its objectives, the proposed action methodology, expected roles and responsibilities of personnel; areas of cooperation and coordination in the community participation process.

The set of expected roles which were identified and listed for the different category of health personnels in the primary health centre were then finalised in consultation with the district health officials and the supervisors at the PHC and communicated to all concerned. This was to ensure their fullest participation in the total planning processes of the project.

The health team took the lead in the identification of the Health Sub-Centre level Health Committee (HSCHC) members, formation of the HSCHC, selection of the Female Community Health Activist (FCHA), the training of HSCHC members and FCHAs and in the utilisation of the HSCHC members and the FCHAs for improving the existing health services delivery. Participation by health teams continued in organising the HSCHC meetings, attending the health committee meetings, helping staff and personnel in solving problems identified, guiding and reorienting the HSCHC members and the FCHAs in performing their roles both in the HC meetings and in field situations.



## **2. Identification, training & formation of HSCHC:**

One male and one female influential leader for every 500 population (100 households) were identified by sociometric method to represent as members to the HSCHC. Each HSC serves a population around 5000. Thus there were 20 members (10 males 10 females) in each HSCHC. This HSCHC functioned as the grass-root level organisation for community participation through communicating the felt needs of the people whom they represent to the health agency, in selecting the FCHAS to work for every household, getting greater cooperation from people etc. The HSCHC met once in every month, reviewed the progress of work and planned the future activities. Each HC functioned under the leadership of an elected president (male) and Vice-President (Female) selected amongst themselves. The Health Team participated in all these meetings and guided the committee members in their planning processes.

The minutes of each meeting was circulated to all the health committee members and to all those involved.

A two days educational session was organised involving the health personnel to orient the HC members on the areas of community participation in improving MCH & FW services acceptance, expected roles in the community and as a member of the HC, their functional relationship with FCHA and health personnel, in identifying the problems, and in planning, mobilising, implementing and evaluating the programmes. This orientation was focussed mainly on the 'know-how' and 'do-how' and was community based and practice oriented.

The formation of the HSCHC gave scope for identifying the local health problems, identifying the felt needs of the people, suggest ways to overcome the problems, ways to approach the community, help spread the message, among the community, set examples, to provide support for their groups, to organise health education activities, and to help the health workers & FACHAS in developing good working relationship with the community.

## **3. Selection, training and utilisation of the FCHAS:**

One FCHA with not less than eight years of schooling, married with one/two child(ren) and adopted one or other family planning method was selected to work as a grass-root level volunteer for every 1000 population (approximately for every 200 households covering one or more villages).

The FCHA selection was made in consultation with HC members and the area health personnel to ensure cooperation and coordination during the action phase. The FCHA was paid a monthly honorarium of Rs.150/- and a

performance based incentive to sustain her interest during the action phase of the project. She worked under the immediate supervision and guidance of her respective area health workers and HSCHC members.

She was trained by the Health Team and project personnel of the Institute for three weeks to take up the specific aspects of MCH & FW activities such as health education in general and with special reference to MCH & FW, ensuring early ante-natal registration, high risk identification, distribution of FST and Disposable Delivery Kit (DDK), helping the female health worker (FHW) in MCH clinic, treating minor ailments, keeping a simple record of the activities carried out, to serve as a depot-holder for conventional contraceptives, and her role as a liaison between community and health personnel and in maintaining functional relationship.

The trained FCHA worked for every household in her area, effectively motivated her community to demand MCH&FW services and to participate in the decision making processes such as planning, monitoring, evaluating and giving feed back to the providers of these services. The process ensured greater cooperation from her area people for the MCH&FW service acceptance.

#### **4. Formation of a Steering Committee:**

A steering committee was formed to monitor the activities during the action phase. This committee met once in every month, reviewed the progress of work, analysed the problems if any (in the programme and in the functional relationship amongst health personnel, health committee members and FCHA) and took timely actions to solve them and to plan the further activities, with such improvements as necessary. The members of this steering committee were (i) district level health officials, (ii) PHC medical officer, block health supervisor, block extension educator and the community health nurse, (iii) block development officer (since development programmes were also to be integrated in this approach), (iv) the presidents of the HSCHC and (v) the project coordinator (Institute representative). The proceedings of this meetings were recorded and circulated to all those concerned to keep them abreast of the actions taken in the light of the project objectives.

#### **5. Self-care services in the community:**

One of the objective of the project is to generate self care services within the community particularly with regard to minor ailments. A revolving fund was therefore created for the purchase of medicines etc. The project provided initial 'seed money' at the rate of one rupee per individual with 'an equal contribution from the community'.



The baseline survey gave an idea about the commonest diseases that are prevalent in the project area. Based on this, the essential drugs for treating minor ailments were purchased out of the seed money of Rs.1000/- earmarked for each FCHA area and were supplied to FCHAS.

All the FCHAS were trained during their 3 weeks training to treat minor ailments. Each FCHA after proper understanding of the reported ailments, treated the cases in strict confirmity with the guidelines which was prepared and used during their training programme. The guidelines spelt out the details such as a) the name of the drug, b) curable disease c) sale cost (on no profit and no loss basis), d) dosage for age, e) time schedule, and f) precautions (if any). Further she sold the drugs at a stretch for a day's requirements only and cases not responding to the treatment after three days were referred to the referral centres.

The FCHA maintained the medicine stock and issue register which was scrutinised by the health personnels and HC members regularly; medicines were replenished periodically out of the sale proceeds.

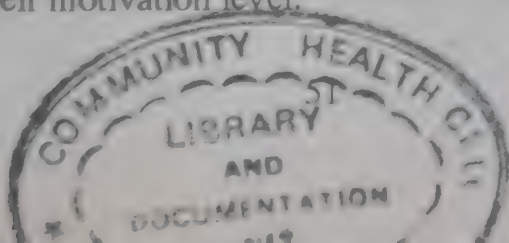
#### **6. Dais training to ensure skilled attendance at delivery:**

One of the objective of the project was to ensure cent percent skilled attendance at delivery during the action phase of the project. Around 750 deliveries were expected in a year in the project area; out of which 50% shall have to be covered by regular FHC staff and the rest by the trained dais.

The baseline data revealed that there were 25 trained dais in the project villages. Out of these 25 trained dais, 5 left the project villages before the action phase and 10 were too old to conduct the deliveries even during the day time itself. There were only 10 trained dais left for conducting deliveries in the project villages.

So in order to revitalise the existing intranatal services, the untrained traditional birth attendants (TBAs)/interested new women in the project villages were identified and were trained for 30 working days (in collaboration with the district and PHC personnel) in conducting scientific and hygienic deliveries. They were provided with a delivery kit and were utilised along with the existing trained TBAS. Out of the 10 traditional birth attendants, who were identified, trained and utilised during the project period, four were FCHAs interested in conducting deliveries. This ensured the availability of one TBA for every 1000 population in the project area.

The Tamil Nadu Health Department provides Rs.3/- as an incentive for conducting deliveries by the trained dais using scientific/hygienic method. The PHW ensured the regular payment of this remuneration to these trained dais and thus sustained their motivation level.



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## **7. Functional relationship between health personnel, FCHAs and HSC HC members:**

When individuals not equal in age, sex, status, literacy levels and so on are formed into a team for a common purpose, the unanimous decision of the team members is a must for the harmonious, progressive and goal oriented functioning. The project team which consist of the health personnel, the FCHAs, the HSCHC members shared their individual ideas and if necessary altered them to achieve the project objectives. Thus the psychological interactions among the health personnel, FCHAs and the HSCHC members were well taken care. Clearly defined roles and functional relationships helped to reduce conflicts. This helped to develop a sense of belongingness, an attitude of selflessness, mutual understanding, and team spirit towards the achievement of common goals. It also helped to mould the team into a cohesive unit.

## **8. Use of HSCHC/ Steering Committee meeting minutes in the project planning processes:**

The monthly HSCHC and steering committee meeting minutes were circulated every month well in advance before the next meeting to all the participants. The decision were closely monitored for their implementation. This also gave scope for studying the process/dynamics of community participation in MCH&FW service programmes.

## **9. Project monitoring:**

The Institute committee, the district/PHC health team, the steering committee constituted for specific purpose and the HSCHC monitored the entire project processes during the action phase.

The Institute committee reviewed the progress of the action methodology very often and suggested ways and means for better implementation.

The health team, apart from sharing their views during the PHC weekly review meetings, also helped and guided the health committee members, and the FCHAş during their field visits (and in the HSCHC/streeing committee meetings) in preparing them for greater community participation and involvement in maternal and child health and family welfare programmes.

The steering committee met once in a month and monitored the project activities by sharing their observations in the light of the project objectives.

The HSCHC which met once in every month discussed the total planning processes and thus monitored the project functioning. The decisions of the Institute committee, the health team, and the steering committee were shared every month in the HSCHC meetings and actions were initiated in order to

sustain the participation level of the HC members, FCHAS and the Health Team.

**SUMMARY OF FINDINGS AND CONCLUSION:** The informations that were collected (during the pre and post project periods) through different surveys and the programme records were utilised to assess the process and the progress of the project intervention. The ‘summary’ of the major findings and the ‘conclusion’ about the project methodology are discussed in detail below.

### **1.Community’s awareness and opinion bout the project:**

The terminal evaluation data collected on, the community’s awareness and usefulness of the project led to some of the following findings.

The knowledge about the project is known to 89% of wives and 91,0% husbands in the project area.

of those who have know ledge about the project, 77.22% Wives and 81.2% husbands have expressed knowledge about one or other activities carried out under the project.

Knowledge about the HC members were reported by 50.3% husbands and 35.75 wives. of those who have knowledge about HC members, 84.6% wives and 82.1 % husbands have expressed that the HC members services were useful.

Of those who have knowledge about the project, 89.0% wives and 91.0% husbands have expressed knowledge about the HC functioning in their area.

The knowledge about FCHA was reported by 99.5% wives and 98.6% husbands.

All the wives and husbands who knows about the FCHA reported that they have knowledge about the one or other activities carried out by the FCHA.

The treatment of minor ailments by FCHA was reported by 86.55% wives and 87.2% husbands.

Health education on health including MCH & FP etc., by the FCHA was expressed by 73.6% wives and 76.1% husbands.

The FCHAS assisted the health personnel in their activities was said by 37.2% wives and 42.1% husbands.

3.4% wives and 2.6% husbands have told that the FCHA distributed nirodh and oral pills and they may be he direct beneficiaries from the FCHAS.

64.9% wives and 64.7% husbands have reported that they had received one or other help from the FCHA.

48.8% wives and 48.4% husbands have expressed that there is improvement in the MCH & FW service utilisation because of FCHA functioning.

A higher percentage of wives (61.0%) with less than 2 years child (births occurred during the project period) have expressed improvement in the MCH & FW service utilisation compared to the wives (45.6%) with more than 2 years living child.

94.2% wives and 48.4% husbands have expressed that the services of FCHA should be continued. The observed higher percentage reported by wives may be due to the fact that they are the direct beneficiaries of the FCHA services.

## **2. Health personnel's perception about the project:**

A review of the health personnel's perception about the project highlights the following:

The discussions in health committee meetings were useful in identifying the village health problems and its solutions, including how to approach the community and how to spread the message of promoting MCH & FW programmes with the cooperation and involvement of the community.

The health personnel at different levels stated that the roles performed by the health committee members were supportive in nature in relation to their job functions.

The responses of the health personnel reveals that the FCHAs either directly or indirectly assisted them in one or the other of their activities.

The responses also indicate that because of FCHAs assistance in the health, MCH, family planning and immunisation programmes, there is a considerable increase not only in the awareness but also in the service utilisation in the project area.

It is observed from the response pattern that the FCHA services are to be continued in the existing Government health system which will help to improve the health service utilisation to a greater extent.

The health personnel are of the opinion that the treatment of minor ailments by the FCHA is to be continued since it is acceptable to the community because of its availability, accessibility and affordability.

The health personnel expressed the view that the health committee functioning to be continued for better utilisation of the health care facilities by the community.

## **3. Programme achievements:**

The findings of the pre and post evaluation are given in the annexure. These findings reveal that there is an overall improvement in the awareness and utilisation of MCH, immunisation, diarrhoeal management and family planning services. The programme wise salient findings are listed below:



### **3 (a) Maternal and Child Health Programme:**

An overall improvement in the knowledge and practices relating to pregnancy registration is observed amongst the project community. The knowledge about pregnancy registration has increased by 25.2%. Around 62.1% increase was also observed in the before 20 weeks pregnancy registration practices. The practice of registering the pregnancy with the female health worker has increased by 5.0%. The intra-spouse communication on pregnancy registration practices has increased by another 25.2%.

Nearly 35.1% increase is observed in the female health worker visit to the pregnant mother before 20 weeks of pregnancy.

The TT and FST services received from the female health worker have increased by 9.5% and 6.8% respectively. The health education services for family planning motivation have increased to the tune of 54.9%.

The number of pregnant mothers received TT immunisation from all sources increased by 35.5% and 23.1% increase is observed in receiving the first dose of TT immunisation before fifth month of pregnancy.

Utilising the FST services during pregnancy, from all sources have increased by 42.4%.

The skilled attendance at delivery in the project area has increased by 22.4%. Further around 50% of the total deliveries in the project area were conducted by the female health worker during the project period, which is one of the objectives envisaged under the project.

### **3(b) Immunisation (child) programme:**

Around 8% to 12% increase is added during the project period in the already existing higher knowledge level about the different immunisations among the community. This observed higher knowledge level may be due to the implementation of the UIP programme right from November 1987 and the steps initiated by government on mass awareness programmes.

The knowledge on the specific diseases prevented by the different immunisation programme which was very meagre during the baseline survey has increased by 54.0% to 76.8% on different immunisations.

Though only 20.5% increase is observed in the case of measles, around 53.2% to 59.6% increases is observed regarding the knowledge of the age at which the first dose of the different immunisation are to be administered to the child.

The children covered (all doses) by BCG have increased during the project period by 41.6%, in the case of DPT by 34.5%, 35.4% by polio and 26.2% by measles,

The wide gap in the practices as to the age at which the child has to be administered the first dose of different immunisations and the actual age at which the immunisation was administered has narrowed down to a very great extent during the project period. This is observed from the increase in the immunisation coverage within scheduled time ie., 20.0% increases in BCG, 20.4% increases in DPT, 21.1% increase in Polio and 70.1% increase in measles.

The immunisation service rendered by the female health worker were increasingly utilised by the project community during the project period. This is evident from the 18.6% increase in BCG, 20.5% increase in DPT, 20.6% increase in polio and 34.1% increase in measles.

### **3.(c) Diarrhoeal management:**

The knowledge about feeding the child during diarrhoea in the project area has increased by 39.8%.

The knowledge about the availability of ORS packets with the HSC has increased by 36.8%.

The knowledge about the preparation of ORS at home has increased in the project community by 25.6%.

### **3(d) Family Planning:**

The desired number of children per couple has come down from 2.4 to 2.2 in the project area and the number of couples willing to have only 2 children has increased by 9.8% and this increase is still more (12.2%) among wives.

The 18.4% increase in the project community on the ideal interval (more than 34 mean months) between two consecutive births, when practiced, will help to a greater extent in postponing the pregnancies.

The knowledge level of the project community has increased by 8.7% on vasectomy, 33.1% on IUD, 42.4% on oral pills and 36.0% on condoms. The project community reported that health staff are their source for information for the different family planning methods. The observed increases in this regard are 4.4% for tubectomy, 6.1% for vasectomy 16.7 for I.U.D., 16.2 for oral pills and 24.0% for nirodh.

The intra-spouse communication about family planning adoption has increased by 16.3%.

Over 31.1% of the eligible couples started realising that family planning adoption will help to better mother's health.

The Couple Protection Rate at the end of the project (1990) was 53.6% compared to 38.5% at the beginning of the project (1988 end). The total number

of eligible couples started practicing one or other family planning method during the project intervention period (two years) has increased by 15.1%

The number of couples started practicing temporary family planning method during the project period also increased in the case of IUD by 1.2%, oral pills by 0.6% and nirodh by 0.8%. The mean number of children of the mothers at the time of tubectomy adoption also reveals a shift from 3.1 during the pre-project period to 3.0 during the project period.

The number of couples expressed one or other complications due to family planning adoption started withdrawing their complaints during the project period and this is evident from a decrease of 12.0% response among the community.

**CONCLUSION:** It may be apt to say that the objective of the study has been largely achieved. This is evident from the health personnel's involvement in and perception about the project and the observed improvements in the community's knowledge and utilisation of the MCH, immunisation and family welfare services delivered by the health personnel in the existing government health infrastructure.

With in the framework of the project, self reliance has been achieved and the project sustenance depends on the follow-up by the health team in the existing health infrastructure. (At block level the cost of running the Health Guide Scheme will be around Rs. 1.5 lakhs per year, which will be less than 10% of the total cost of the existing health care delivery at block level in the rural areas of Tamil Nadu.)

The experiences of earlier attempts indicated that the community which got involved deeply or motivated, if not given supportive help after optimal motivation usually boomerangs. Such an apprehension may hold true in this project also if adequate follow-up provisions are not provided.

However, the one day seminar organised after the action phase (involving all those in the project) gave an insight that the community in the project area is highly motivated and enthused to a large extent and they demanded extension and sustenance of the project.



TABLE. A. KNOWLEDGE AND PRACTICE INDICATORS ON HCH  
(in percentage)

Statement No.	Indicators	WIFE			HUSBAND			BOTH	
		Base- line (N=522)	Evalua- tion (N=428)	Base- line (N=511)	Evalua- tion (N=391)	Base- line (N=1033)	Evalua- tion (N=819)		
1	Knowledge about FHW activities	91.8	99.8	83.8	99.5	87.8	99.6		
2	(a) Knowledge about the frequency of visits of the FHW	91.2	95.7	79.5	96.6	85.4	96.1*		
	(b) Knowledge about fortnight visits of FHW	47.3	52.0	51.1	54.6	49.2	53.0		
3	(a) Knowledge about pregnancy registration	78.9	98.4	66.7	97.7	72.9	98.1		
	(b) FHW/FCHA is the source of pregnancy registration	74.8	83.8	73.3	87.7	74.1	85.7		
4	(a) Consulted for advice and help during Pregnancy with FHW.	57.7	90.6	52.3	87.4	55.2	89.0*		
	(b) Received immunization advice from FHW	79.2	100.0	73.4	98.9	74.5	99.4*		
5	(a) Last pregnancy was registered	83.3	91.3	80.9	94.3	82.2	92.8*		
	(b) Last pregnancy was registered with FHW	93.9	100.0	96.4	100.0	95.0	100.0*		
6	Last pregnancy registered with less than 20 weeks of pregnancy.	16.0	67.9	12.0	85.5	14.2	76.6*		
7	Discussed about pregnancy registration with spouse	28.2	50.7	47.4	82.2	37.2	62.4		

SOURCE: Baseline (September 1988) and Post-Evaluation (May 1991) KMP Survey

\* Evaluation responses are based on sample respondents (Wife - 92 and Husband 88 ) with less than two year living child.

Statement No.	Indicators	WIFE		HUSBAND		BOTH	
		Base-line (N=522)	Evaluation (N=428)	Base-line (N=511)	Evaluation (N=391)	Base-line (N=1033)	Evaluation (N=819)
8	a) FHW visited during last pregnancy	-	-	-	-	58.0	80.6*
	b) FHW visited within 20 weeks of last pregnancy	-	-	-	-	45.7	80.4*
9	Service received from FHW during last pregnancy	61.7	78.3	50.7	86.4	56.2	82.2*
	a) TT service received from FHW during last pregnancy	85.1	94.3	84.2	94.1	84.7	94.2*
	b) FST service received from FHW during last pregnancy.	87.6	92.7	84.0	93.3	86.2	93.0*
	c) Received health education on FP motivation during last pregnancy.	34.2	79.4	28.6	93.7	31.7	86.6*
10	TT immunisation received during last pregnancy from all sources.	64.6	95.7	58.7	98.9	61.7	97.2*
11	First does TT immunisation received before 5th month of pregnancy during last pregnancy.	40.0	56.1	26.6	57.6	33.8	56.9
12	FST tablets received during last pregnancy from all sources.	53.5	92.4	46.0	92.0	49.8	92.2*
13	Skilled attendance at delivery	43.4	65.2	47.5	70.5	45.4	67.8*

**TABLE-B. KNOWLEDGE AND PRACTICE INDICATORS ON IMMUNISATION (CHILD)**  
(in percentage)

Statement No.	Indicators	WIFE		HUSBAND		BOTH	
		Base-line (N=522)	Evaluation (N=428)	Base-line (N=511)	Evaluation (N=391)	Base-line (N=1033)	Evaluation (N=819)
1	Knowledge about different Immunization						
	(a) BCG	86.0	99.5	86.3	99.0	86.2	99.3
	(b) DPT	92.5	99.8	92.4	100.0	92.4	99.9*
	(c) Polio	91.0	99.8	91.4	99.5	91.2	99.6*
	(d) Measles	74.9	90.0	82.8	91.3	78.8	90.6*
2	Knowledge on specific disease prevented by						
	(a) BCG	21.8	70.7	18.1	77.7	20.0	74.0*
	(b) DPT	17.4	92.5	13.1	91.8	15.3	92.1*
	(c) Polio	35.2	89.7	29.1	91.5	32.1	90.6*
	(d) Measles	14.0	70.7	12.3	74.8	13.2	72.6*
3	Knowledge on the age (within the scheduled time) at which the child is to be given immunisation.						
	(a) BCG	25.2	80.5	16.4	80.4	20.8	80.4*
	(b) DPT	14.5	64.5	12.1	69.1	13.3	66.5*
	(c) Polio	14.8	63.9	11.8	69.6	13.3	66.7*
	(d) Measles	62.4	79.0	59.3	83.7	60.8	81.3*



Statement No.	Indicators	WIFE		HUSBAND		BOTH	
		Base-line (N=522)	Evaluation (N=428)	Base-line (N=511)	Evaluation (N=391)	Base-line (N=1033)	Evaluation (N=819)
4	Administered immunisation (complete doses to the last child)						
	(a) BCG	43.3	82.6	39.0	83.0	41.2	82.8*
	(b) DPT	60.1	92.4	56.4	93.2	58.3	92.8*
	(c) Polio	58.2	91.3	55.3	93.2	56.8	92.2*
	(d) Measles	12.6	44.6	13.7	34.1	13.2	39.4*
5	Immunisation was administered within the scheduled time to the last child.						
	(a) BCG	74.3	88.4	61.8	88.3	68.4	88.4*
	(b) DPT	69.8	88.2	64.9	86.9	67.4	87.8*
	(c) Polio	69.1	88.6	64.7	87.6	67.0	88.1*
	(d) Measles	24.2	91.5	15.7	88.4	19.9	90.0*
6	Immunisation services received from the FHW						
	(a) BCG	35.8	58.2	29.1	43.8	32.7	51.3*
	(b) DPT	67.2	82.4	59.0	85.4	63.3	83.8*
	(c) Polio	67.1	82.4	59.2	85.4	63.2	83.8*
	(d) Measles	48.5	85.4	34.2	65.0	41.2	75.3*

TABLE-C. SELECTED DIARRHOEAL MANAGEMENT INDICATORS  
(in percentage)

Statement No.	Indicators	WIFE		HUSBAND		BOTH	
		Base- line (N=522)	Evalua- tion (N=428)	Base- line (N=511)	Evalua- tion (N=391)	Base- line (N=1033)	Evalua- tion (N=819)
1	Knowledge about feeding the child during diarrhoea	33.1	72.7	32.7	72.6	32.9	72.7
2	Knowledge about the availability of ORS packets.	53.4	86.2	42.9	83.4	48.1	84.9
3	Knowledge about preparation of ORS at home	19.4	42.4	8.0	36.4	13.8	39.4*

TABLE-D. SELECTED KNOWLEDGE AND PRACTICE INDICATORS ON FAMILY PLANNING.  
(in percentage)

Statement No.	Indicators	WIFE			HUSBAND			BOTH	
		Base-line (N=522)	Evaluation (N=428)	Base-line (N=511)	Evaluation (N=391)	Base-line (N=1033)	Evaluation (N=819)		
1	a) Desired number of children (mean)	2.4	2.2	2.3	2.2	2.4	2.2		
	b) Number of couples desired to have two children	66.8	79.0	72.0	79.5	69.4	79.2		
2	a) Ideal interval between two consecutive births (Mean months)	32.4	33.7	31.0	34.4	32.2	34.0		
	b) More than 31 months is the ideal interval between two consecutive births.	62.8	76.6	55.8	79.3	59.4	77.8		
3	Knowledge about FP methods								
	- Tubectomy	100.0	100.0	100.0	100.0	100.0	100.0		
	- Vasectomy	84.3	96.3	93.2	98.7	88.7	97.4		
	- IUD	56.5	89.5	53.2	86.4	54.9	88.0		
	- Oral pills	43.3	86.2	40.7	82.6	42.0	84.5		
	- Condom	39.1	84.1	51.7	85.9	49.0	85.0		
4	Health staff reported as source of information on FP methods								
	- Tubectomy	36.0	43.0	36.0	37.6	36.0	40.4		
	- Vasectomy	29.5	41.0	31.5	32.1	30.6	36.7		
	- IUD	34.6	45.7	14.3	37.0	24.9	41.6		
	- Oral pills	34.1	45.0	15.9	37.5	25.3	41.5		
	- Condom	28.4	50.0	10.6	33.0	17.8	41.8		



Statement No.	Indicators	WIFE			HUSBAND			BOTH	
		Base-line (N=522)	Evaluation (N=428)	Base-line (N=511)	Evaluation (N=391)	Base-line (N=1033)	Evaluation (N=819)		
5	Discussed with spouse about FP adoption	49.0	65.2	46.8	63.2	47.9	64.2		
6	a) Favourable opinion about FP adoption	82.0	93.5	82.6	90.1	82.3	91.8		
	b) Mother's Health-Favourable opinion reason expressed.	17.1	45.3	12.3	47.2	14.7	46.1		
7	a) No. of couples currently adopted one or other FP method.	-	-	-	-	38.5	53.6		
	- Tubectomy	-	-	-	-	36.8	49.0		
	- Vasectomy	-	-	-	-	0.2	0.5		
	- IUD	-	-	-	-	0.6	1.8		
	- Oral pills	-	-	-	-	0.5	1.1		
	- Condom	-	-	-	-	0.4	1.2		
	b) No. of children at the time of Tubectomy adoption (mean)	-	-	-	-	3.1	3.0		
8	Faced complication due to FP adoption	58.1	38.4	47.4	43.6	52.8	40.8		
9	a) Willingness to adopt FP method in future	19.9	29.0	17.3	32.1	18.6	30.5		
	b) Baseline willing couples adopted one or other FP method during the action phase.	-	-	-	-	-	66.0		
10	a) Birth rate ...	-	-	-	-	32.0	25.5		
	b) Death rate ...	-	-	-	-	11.0	10.3		

# 6 PLANNING, IMPLEMENTING AND EVALUATING PROGRAMME FOR PEOPLE'S INVOLVEMENT IN ENVIRONMENTAL HEALTH PROGRAMME, PARTICULARLY WITH RESPECT TO WATER SUPPLY AND SANITATION

*Dr. K. Balachandra Kurup*

## 1. INTRODUCTION:

People's involvement or participation has been used very frequently by many implementing organisations without realising the implications of such involvement in development programmes. People's participation is considered as the main spring of social development, yet this is more often rhetoric than reality. The basic needs approach with bottom-up planning came to existence in paper and press for a long period. Majority of the developing nations accepted this concept to the extent that it has become a fad and fashion to talk of grass roots level planning or decentralised planning. The delegation of power to local government assumes significance when decentralisation of decision making and implementation in matters of socio-economic planning takes into account people's participation. For the implementation, monitoring and evaluation of development planning there is a need to establish a system for improved periodic monitoring of social conditions, behavioral practices and social set up of the areas. For improving the quality of life and implementing activities effectively as at the local level an organisational net work or social group is imperative. This local unit should be given structural identity, delegation of power in principle and practice, decision making power on socio-economic development of the locality, required financial resources (as a rolling fund) to develop community consensus and commitment in the management of the social and economic upliftment of the area. Development cannot be done without proper and conscious organisation at the local level. It is believed that

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programme implementation should be done to a large extent by the people at the local level themselves, with assistance from any 'appropriate' technician. As a matter of fact, in Kerala the Panchayats ward can be considered as an appropriate local unit, since it has a compact area with adequate population density.

In many countries significant numbers of water supply points and sanitation systems are not operational. A sociological review of rural water supply and sanitation efforts in the past decade (1981-1990) reveals that access to safe water does not necessarily imply consumption of safe water. The study further reveals that appropriate use of water and people's behavioral practices (on handling water, collection, storage etc..) are more prudent than just the provision of safe water. The reasons for these failures were originally assumed to be due to use of inappropriate location and technology. Now planners and technologists are aware that many problems also arise because the consumers of these services, that is the local community, have not been sufficiently involved in the design, implementation, operation and maintenance of their own water supply and sanitation facilities.

**The World Development Report 1992** makes an emphatic statement that "investments in sanitation and water offer high economic, social and environmental returns".

However, these returns are realizable only with the effective utilisation of the facilities provided. It is in this context that the attempt to mobilise people's participation in water and sanitation programmes acquires vital importance.

In this paper an attempt has been made to review the experience of Socio-Economic Units in the planning, implementation, monitoring and management of water supply and environmental sanitation programmes with People's participation.

*Those who are not familiar with the programme kindly note that Socio-Economic Units, is an integrated drinking water supply and sanitation programme funded by the Governments of Netherlands and Denmark working closely with the Kerala Water Authority. The long-term objective of the programme is to improve the health and living standards of the people. The SEU has a three level functional structure. At the headquarters the tasks of project planning, co-ordination, support and monitoring undertaken by a small professional team. In the field, the main functions are implementation and co-ordination. Co-ordination with other agencies, including the government, in matters of sanitation, health and education is an equally important component of the programme at this level. Each field office have 4 to 6 lakhs population.*



*At the third level (at panchayat level) the temporary field organiser is working together with the Water Committees, Standpost Caretakers and the Community where the project is being implemented.*

## **A. People's participation & mobilisation:**

1. The core element of the project is to ensure people's participation through the involvement and mobilisation of the communities in the selection of new water supply schemes, location of public standposts, to identify the areas where extensions are required, selection of beneficiaries for sanitation programmes, location of sites for latrines, monitoring the conditions of water points and use & maintenance of latrines, organisation of hygiene education programmes and beneficiary meetings at the ward level. People's participation in a social development programme should be viewed as something more than a concept. It is rather a flow that determines the success of the project. To keep this in mind Ward Water Committees (WWCs) have been established as an integral part of the project. These representative groups from the locality determine patterns by which water supply and sanitation programmes can be implemented in their locality. With the help of WWCs, it is possible to promote effective dialogue and articulation of interest of the community in the scheme. It is worthwhile to mention here that participation as an end may appear only in part as designed programmed output, while in other forms it usually appears as a by product of the programme. In connection with this, Combs has stated that-

“The formation of local pressure groups is necessary to bring about structural changes and reforms, to achieve a more suitable sharing of the benefits of development, to demand better services from government agencies, or to exercise a large voice in policy and programme decisions affecting their lives”.

2. The Water committee consists of seven members nominated by the community. They are (1) elected Panchayat member, (2) Two women representatives, (3) Two representatives of Youth organisations, (4) An

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1 By way of background, it should be noted that a panchayat, in Kerala, has an average population about 2500 people. These people do not live in clustered villages but live along roads and paths throughout the panchayat. In the areas where the Socio-Economic Units work, the population density for these rural areas ranges from about 900 people per square kilometer to 2600 people per sq.km. Each panchayat is divided for administrative purpose into wards whose population averages about 2500 people.

active social worker or school teacher, (5) representative of ICDS/health department depending on their involvement in the programme.

3. The guidelines to select the WWC members and their responsibilities are indicated in the water committee training manual.

The members of the WWCs are selected democratically after considering their competency, dedication and motivation. The SEU has developed a training manual with a curriculum for training the WWC members. Besides, this manual includes the composition of WWCs, guidelines to select WWC members, their responsibilities and proceedings of the meetings. For convenient purposes the activities are divided in three strata:

- (1) Water related (mainly piped water) activities,
- (2) Sanitation related activities,
- (3) Community education, including traditional water sources.

## **B. Water related activities:**

1. The important water related activities are: (a) mapping and site selection of public stand posts; (b) reporting of leaks and faults (monitoring the stand posts use); (c) up keep of the surroundings of standposts; (d) prevention of misuse & vandalism; (e) closing down of undeserving taps; (f) experiment on use and maintenance by the community; (g) experiment on cost recovery; and (h) design of user friendly standpost with drainage.
2. **-Mapping & site selection of public stand posts:** SEU has added a social dimension to engineering activities: the central involvement of the people in mapping, identify the areas to be included in the water supply schemes, and deciding the location of public standposts. The maps include data on the dwelling places of rich, middle and poor income families, colonies, roads, foot paths, market places, schools, dispensaries/hospitals, ICDS centres and so on. Maps have been prepared for each ward (scale of 1:5000). In some of the training classes the water committee members have been asked to prepare the ward maps of their areas indicating the current location and size of pipes and standposts. It is realised that such maps can be utilised for the design of water supply schemes due to absence of detailed update maps of each localities. So far, SEUs have prepared detailed maps of 52 panchayats.
3. This process closely involves the community in the planning and design of water supply schemes. More over, through such exercises detailed design can be worked out and priorities the area of operation based on the

available resources. The other areas can be catered to at a later stage without much investment.

4. Earlier the siting of the standposts were often on political considerations and community were not asked or involved in the identification of water points. The tendency of many politicians and KWA staff were to add on new lines and standposts, (based only on political criteria- under drought scheme, IHDP scheme etc., ... ) without studying the capacity of the schemes and water demand. This was mainly due to lack of established guidelines on standpost location.
5. Based on the field experience of the SEUs, Kerala Authority, (K.W.A.) issued guidelines on site selection criteria: a stand post should be served for minimum 15-40 households (about 200 people) within a minimum walking distance of 250 meters radius. Following this criteria the number of public stand posts can be curtailed and focus on stand posts can be given to the colonies and place where the poor and needy people are residing. As indicated above from the mapping exercise the economical and social status of the households can be stratified in to three: (a) rich for house connection; (b) Middle-income- for house connections and (c) poor-for public stand posts. Since the local bodies have to pay Rs.875 in the rural areas and Rs. 1314 in the urban areas per annum for operation and maintenance of stand posts it may be advisable to control the use and maintenance of such taps by the users themselves. It is worthwhile to add here that experience gathered during the mapping and site selection exercise will be used for the identification of future water supply scheme in Kerala.
6. **-Reporting of leaks and faults (stand post monitoring):** This is one of the most important and difficult activities of the water committees and Stand post Caretakers (SPC). This activity has been tailored for assisting the KWA in better operation and maintenance of the scheme or improving the service delivery. In the beginning, reporting was done by telephone to KWA office on a haphazard manner by the WWC, Panchayat and Field Organisers of SEU. Later the Field Organisers and WWCs collected the list from the SPCs and handed over to KWA. In the present system KWA had agreed to maintain a register at each panchayat office and keep all the forms in the register itself. However, line leaks and other serious faults will be dealt immediately by the KWA. In another area, printed post cards have been given to the SPAs and this will be posted when there is a tap leak or line breakage. All such reporting coming from the field will be consolidated by the respective KWA staff. It may be worthwhile to note



that with the active participation and involvement of the WWC, SPAs and the Community, KWA has been able to improve the service level from 30% to 80% in one of the schemes during the past six months. The quality of taps is still being investigated and in some areas it has been decided to use plastic taps instead of Jayson taps. In addition to the regular reporting the SPCs monitor the supply of water, its colour, and taste. However, the latter activities have not been given much attention mainly due to the stabilization of schemes.

7. **-Up keep of the surroundings of stand posts:** The SPCs and WWCs have been given the task of keeping the surrounding of the platform and other areas clean. In many of the standposts local drainage have been constructed under the leadership of SPCs and WWCs. The SPCs have been taken up this voluntary job as a challenge. As a part of training they were asked to vouch and comment on the keep of the neighbouring stand posts. School health club members (students) have been used for assessing the condition of standpost coming under their jurisdiction. In certain areas prizes and certificates have been distributed to the SPCs who maintain clean stand posts.
8. **- Preventing misuse and vandalism:** There is tendency among many Keralites that public stand post are meant for all type of uses, such as washing autos, bicycles, trucks, washing cloths and even watering the coconut plantation of an influential person. Some time the users themselves use sand, stones, iron wires, threads etc... for lifting the mouth of the tap due to irregular supply or the pressure is very low. Such type of actions have been considerably reduced in scheme areas due to stimulating efforts of the SPCs and WWCs.
9. **- Closing down of undeserving stand posts:** Before undertaking this the general impression of many KWA staff and Panchayat presidents and members was that it is not possible to close down the existing taps. Firstly, KWA engineers expressed that Panchayat will never come up with a resolution for closing down the stand post. More over these stand posts were erected during 1987/88 before the establishment of Socio-Economic Units in Kerala. Probably due to active involvement of WWCs and SEUs together in site selection realised the need for closing down certain stand posts. (those standposts are not agreeing with the above mentioned site selection criteria) Secondly, the panchayat has to pay Rs.875/= per annum for each stand post. This is also in the best interest of the scheme.... conserving water and improving potential for cost recovery. Beginning with one panchayat, 53 standposts were blocked in one panchayat with KWA, WWC and panchayat personnel working closely together. The

panchayat president and the WWC members were present during all three days in the closing down exercise. This activity has stimulated the other panchayats and the WWCs who have been entrusted with reporting on the underserving standposts.

10. - **Experiment of use and maintenance by the community:** Lack of manpower and funds of the schemes for the operation and maintenance are seriously affecting the quality of service. In order to develop a community based operational strategy a small experiment on use and maintenance of standposts was undertaken in one area. Ten members from the community (5 men and 5 women) have been selected and trained to undertake small repairs at standposts and have been provided with the necessary tool kit. Now the KWA has decided to use the service of the trained members from the community for repairing the standposts and provide support for small connections. Due to bad quality of Jayson taps trained members were able to replace the Jayson taps with the locally available plastic taps. Currently these members are not paid for attending the repair work. However, they will be given payment for their work from the community and the local body. The community is meeting the cost of tap while it is replaced.

11 - **Experiment on cost recovery:** The cost of production of protected water is much higher than what is actually realised by many persons. According to the statistics available KWA has to get Rs. 90 crores from various local bodies and institutions. With the major resources available with KWA it is not practical to continue the distribution of water free of cost. As a way of helping the KWA the last Panchayat finance commission decided to introduce payment for standposts. In the rural area the panchayat has to provide Rs. 875/- for each standpost per annum for cost of water and maintenance charges. The Municipalities have to pay Rs. 1314/= per annum. Eventhough, in principle most of the local bodies agree to this in practice the money was not provided to KWA. The government can make internal adjustments from the grant due to the local body. In one scheme area, the SEUs, WWCs and SPAs have decided to carry out an experiment on cost recovery. The users in the areas have been consulted and asked to contribute according to their economic status. Majority of them agreed to contribute Rs. 5 to Rs. 10 every month as water charges. The intention is to continue this activity through out the scheme and currently this activity has been implemented in 4 panchayats. With this fund the panchayat will be in a better position to settle the amount due to KWA. Although this amount is fairly high among the poorer families, the need for a reliable, accessible and good quality water was the main contributing factor for the majority of them. Another important aspect is



that these poor householders are contributing even during heavy monsoons (when there is no scarcity of water). The area under operation is one of the most backward, sensitive and difficult areas to work. This experiment would be an eye opener for the politicians, planners and policy makers.

### **C. Sanitation related activities:**

1. Improved water supply and sanitation are considered to be the prerequisite site for better health and socio-economic development. It was realised that satisfactory achievement will not be possible through the water supply schemes without adequate sanitation coverage. Several government departments, institutions and voluntary organisations are involved in the rural sanitation programme in Kerala. However, the State lacks a clear-cut strategy and management style to implement community based, low-cost sanitation programme. The low implementation rate of many of the low cost sanitation programme prove this further. The government departments, such as PHED, rural development and health services were entrusted with this responsibility but none of the departments were able to develop a practical and continuing operational plan. When the SEUs in Kerala conceived the programme, it was realised that in spite of all the efforts the coverage of rural sanitation in Kerala was approximately 22% only. The challenge was to provide as many poor households as possible with proper sanitation but in such a way that the beneficiaries; understand and appreciate the facility and will use it properly. This means, in practical terms not only construction but mobilisation and motivation of the beneficiaries; arranging for involvement of local groups and, finally, construction of technically sound latrines at low cost. The given latrine design is of the double pit pour flush latrine with squatting pan. This technology was recommended by GOI, UNDP and UNICEF. It also has advantages in Kerala where the majority of poor people do not have sufficient land to relocate latrines. Most sanitation programmes in Kerala include a complete superstructure, and hence this was also included in the programme. The major challenge then, was not technical, but was managerial and administrative.
2. Therefore, it was decided to have three pilot programmes to try out different institutional arrangements for implementation of the programme. The three programmes which were carried out in 1989 compared planning and implementation with:



- voluntary and semi-governmental institutions (three different institutions with sufficient experience and manpower to manage and construct 500 latrines each in three different panchayats);
  - through the panchayat (local government) and voluntary Ward Water Committee. The Ward Water Committee includes members of active local institutions such as the Health Department, ICDS, schools, youth and women's organizations (tried out in two panchayats, 500 latrines each);
  - by the Socio-Economic Units directly (two panchayats, 500 to 1000 latrines each).
3. In all cases, the double-pit, pour flush latrine was built with superstructure having 20% financial contribution from beneficiary plus digging of pit. This is a programme oriented for the weaker sections of the community. All beneficiary families were to be below the poverty line, with selection based on certain commonly agreed criteria.
  4. Computing the outcomes of these three pilot programmes demonstrated the importance of education, community mobilization and follow-up. The pilot programme carried out through the local government with Ward Water Commodities proved most satisfactory. The work of the voluntary and semi-governmental institutions was weaker in education and in obtaining commitment of the families and community. The work directly implemented by the Socio-Economic Units requires a level of manpower that could probably not be sustained in a larger programme.
  5. The pilot experience also showed the need for adequate time (at least 3 months) before implementation for education and mobilization activities; need to involve health department staff and members of other institutions active locally; the need for follow-up monitoring for at least a year after construction. This has become the model for the programme that is currently being implemented. Provision of effective sanitation for larger number of families require mobilization of already present organizational resources - not to do every thing ourselves but to work through local institutions. The best way to mobilize these is through the panchayat, the Ward Water Committee and the Socio-Economic Units working together.
  6. The programme has three components, of which construction is only one. The main elements of the programme are community and beneficiary motivation and participation, education / communication for improved sanitation and, lastly, construction. Each element is equally important.

7. In terms of **community and beneficiary participation** the programme is carried out by the panchayat, the Ward Water Committee and community working together with the SEUs. The strategy emphasizes community leadership and responsibility for implementation. The various groups involved in the programme are described below:
8. The strategy of the programme is based on a written contract in which the panchayat and the groups noted below agree to manage and implement the programme following certain procedures, together with the Socio-Economic Units. Each panchayat also contributes, on a voluntary basis, for this programme. The amounts range from as little as Rs. 500 to as much as 2 lakh rupees. In most cases the panchayat contribution is used to provide latrines to the very poorest of people at the end of the standard construction period. However, the contribution must be deposited in a bank account, jointly operated by the panchayat and Socio-Economic Unit before the programme can begin.
9. An executive committee looks after the day-to-day affairs of the programmes (including constructions and education activities). The Executive Committee members are: the Panchayat President, Executive Officer, an SEU Official, one lady member (elected by all the WWC members or the women WWC members). The Ward Member from the ward where programme implementation is ongoing, is a special invitee to the Executive Committee. The Executive Officer is responsible for keeping the accounts for this programme. These accounts are checked periodically by the accounts officer from the Socio-Economic Units and are subject to periodical audit by an external auditor.
10. The Ward Water Committee is in charge of general implementation of the programme in each ward. It is important to note that this composition ensures that all active groups, all points of view and all local political interests/parties are represented. The convener of the Ward Water Committee is usually not the elected ward member. The latrine- and education programme is not the only activity of the Ward Water Committee.
11. There is an important education/communication component which is meant to be continuous and community-based. Education and communication activities occur at set intervals:
  - There is a 3 to 6 month general mobilization, with a range of activities such as group meetings, exhibitions, camps, street drama. This is meant to build up demand, inform people about the health aspects of latrines in general.



- Specific training for masons in construction and about imparting health/ sanitation message to the families.
- Three classes for beneficiaries, each targeted on a specific topic (water borne diseases and health, technical aspects, maintenance and use)
- Training and planning activities for the Ward Water Committees and relevant panchayat officials involved in the programme.
- Follow-up monitoring by the Ward Water Committees and other local groups.

2 With respect to construction, the target for this programme is 100% of the below poverty-line households. By 30th September 1993, 18,000 latrines had been constructed in 32 panchayats. Faced with the challenge of construction large number of latrines (currently the goal is approximately 50,000 in 65 panchayats), it was not obvious which management and administrative strategies should be developed, particularly the institutional linkages. The basic latrine model is made, with variations taking into accounts local conditions and availability of materials. This is the double-pit, pour flush latrine, with a complete superstructure. In one panchayat as an experimental basis SEU provided finance upto plinth level construction and the beneficiaries were asked to complete the latrines. Only 66% of the beneficiaries completed the superstructure. In another four panchayats, householders provide three bags of cement, bricks and dig the pits. The SEU and WWC provide the remaining material and organise the education and construction activities. In reality, the beneficiary share is more than 50 %. As of September 1993, the cost of each Unit ranges for Rs. 1680 to Rs. 2300 (except in water-logged areas where costs are higher). The price is different in each panchayat depending on the cost of local materials and labour. Costs are carefully set through the construction of demonstration latrines at the beginning of work in each panchayat. Maximum use is made of locally available materials and local masons for each programme. It is important to keep down the costs because poor families can not afford large contributions (calculated at 20% of construction costs plus digging pits). It is also important to reduce costs in order to stretch our existing resources as far as possible. These costs are relatively lower than in many other programmes because of the high level of community involvement and the special effort to find the lowest cost for construction using local materials. Similarly every three months the use and maintenance of the latrine is also followed up by the representative of the ward water committees.

3 The management and administrative aspects of the programme is developed, step-by-step based on the field reality and experience. The selection



of panchayats depends on two things. First, the panchayats must be those in which the water schemes supported by the bilateral governments are also being implemented. The responsibilities of the panchayat and the SEU has been clearly stated in the contract. The beneficiaries are selected by the Ward Water Committees, based on a set of criteria and this has to be agreed upon by the Ward Water Committee members. While implementing the programme several steps have to be followed and the construction activity is the 10 step out of 13 steps.

- 14 It is noteworthy to mention here that the programme is managed by the water committees with the active support of the Panchayat. As a result of this, the programme has attracted attention by many departments and donor agencies. More over this programme is being projected and accepted as a community welfare activity to promote public health and environmental conditions.

#### **D. Special features of SEU programme:**

- This is the only programme in the State where local body (panchayat) is contributing funds for sanitation programme. (more than Rs. 1.7 millions contributed thus far)
- Through this programme it was possible to bring all leaders in the local area under one umbrella irrespective of their political affiliations.
- The usage rate is more than 90% in all the areas.
- Households are coming forward (mainly middle class) for a sanitary latrine and they are willing to contribute 75% or 100% of the cost of it.
- The proportion of children using latrines is apparently high. But this has to be proved further through quarterly monitoring.
- The unit cost of latrine is less than the other programmes in Kerala.
- Beneficiaries are very satisfied with the performance and the quality of construction. They are aware of the functions of the junction box and the need for changing pits every two years.
- This is the only programme where beneficiaries contribute beforehand. Most other programmes are marked by default household contributions after construction.
- The programme has attracted considerable attention. We have been approached by UNICEF and the World Bank for collaboration. We are currently carrying out two collaborative programmes: (i) with the Department of Fisheries in a coastal panchayat in Thrissur district; (ii)

with the UNICEF through an NGO in a water logged area in Kuttanad (Alappuzha district).

## E. COMMUNITY EDUCATION:

1. As explained in other sections community oriented educational programmes are being built into every stage of the programme. Although, the concept of environmental cleanliness and purity of water are not unfamiliar to the people of Kerala, there is a strong need to strengthen the health education component in water supply and sanitation programmes, especially with regard to reinforcement of messages and incorporation of scientific temper into attitudes towards water handling and usage. Socio-Economic Units (Kerala) with the mandate to explore the links between communities and technical projects like water supply also looks into the questions of water usage and purity and sanitation among other things. A major vehicle for the carriage of messages is the Ward Water Committee. Effective hygiene education requires the combined use of different approaches, like interpersonal communication and group discussions. However, the main thrust is the selection of appropriate, viable and effective approaches or combination approaches for each situation and its effective use. It is easy to make changes in technological aspects but making appropriate changes in attitudinal and behavioral practices is a very difficult task which have to be developed over a period of time. This involves more than simply explaining the importance of hygiene education to the people. Local women groups are selected to form neighbourhood committees and are trained to implement effective hygiene education programmes. Perception and knowledge of the community regarding water and sanitation is crucial before carrying out the programme. It is important to gain insights into the life style and living patterns of the community. A special effort was made to get a feel of the area and the general ambience through identification of surnames, mode of addressing various individuals, people's style of dressing, their aspirations political affiliations and so on.
2. The policy makers and health workers do not give any priority to the programme. Probably, due to other commitments and heavy workload they are ignoring the community level education related to water, sanitation and other environmental aspects. Hence, there is very strong need to reactivate the mentioned activities or establish a separate body to organise and manage effective health education and hygiene practices to make community participation a reality. There is also a need to earmark



five to ten percent of the total budget on water and sanitation for health education and training. Efforts should be made to study and understand how beliefs and attitudes influence behaviour (especially hygienic practices), and thus affect disease transmission. Such feedback may provide useful pointers as well as possibilities for community organisation, participation and education. By and large the community education component had addressed the following issues:

- How can people be successfully motivated to adopt hygienic practices such as hand washing?
- How can hands be washed adequately with minimum water and soap?
- What are the usual local behavioral practices and their trend?

For example there is a common belief that children's faces are 'harmless'. They are often more infectious than adult excreta and can contaminate if they are left in the yard thrown on a nearby garbage heap or if soiled baby clothing's are washed along with dishes. Some families mentioned that the latrine would be of great help especially in case of women who have to go either early or late in the evening to defecate or be beneficial to the women during the menstruation period and be beneficial to the sick or old people.

3. Supportive systems are required to strengthen and enable the communities to respond to the message by organising themselves for active involvement and putting into practice the hygienic practices promoted by health education efforts. Examples of other activities in which the community group creatively involved are:

- reporting of leaks and faults
- upkeep of surrounding of standpost
- upgrading traditional water sources such as wheels and springs
- chlorination campaigns
- excreta disposal facilities with education programme
- water collection, storage and use
- personal hygiene
- garbage waste water disposal, local drainages and other preventive measures against prevalent waterborne diseases.
- fly control campaign

4. Action-oriented and pragmatic community based education programmes will be designed to change the social behaviour while planning the hygiene education programme. It would be worth while to keep in mind



the quotation "health education has often become the scapegoat for all kinds of programme failures. It is easy to blame people (and workers) for programme failures. Planners and administrators would like to change peoples behaviour to fit programme requirements, technology and procedures".

5. **School health clubs:** More than 80 school health clubs have been formed in the selected schools. Through their activities they have improved children's health awareness and behaviour. A book on water was prepared for the school children with input from members of school health clubs and teachers. Based on the experience of the SEU, substantive progress has been seen in and around many of the schools: such as environmental cleanliness around the class room and the school compound, covering the drinking water pots and using a ladle instead of taking water by dipping a hand in the water pot, washing hands before taking food, washing both hands after they go to toilet, percentage of children who regularly do nail cutting and so on. There are many corrective evidences one can draw from the experience of school health clubs.

6. **Training, Orientation and net working with other departments & NGOS:**

Training requirement has been identified from the departments (such as health, social welfare, education, rural development, panchayat) and NGOs and orientation and refresher training were given at the field level according to the need. In addition to this practical training and workshop has been organised for the members of the water committees, standpost attendants and community. Participatory training techniques have been utilised for all the training. They have also been involved in practical field training exercises using observation schedules, home visits and schools health clubs. Together with the water committees it was possible to bring together the elected members and the officials from various departments catering for the upliftment of the rural people. This has been possible mainly due to the effective, sincere and dedicated work of the various actors involved in the community education activities.

Several masons have been trained through out the project area. Thirty two women masons have been trained and they are undertaking latrine construction programmes in 4 panchayats. They will be given same wages like the male masons. The experience of the SEU is that women masons are very effective in communicating with the householders during the construction than the male masons.

## **7. Mass media and radio programme:**

An innovative radio broadcast programme on Protected water supply and environmental sanitation, viz, JEEVADHARA (Fountain of Life) was developed together with the All India Radio, Socio-Economic Units Directorate of health services, State committee of science, technology and environment, Pollution control board, Kerala Sastra Sahitya Parishad (KSSP) and Kerala Association for Non-formal Education and Development (KANFED). Thirty two weekly lessons were broadcast on various aspects related to water source, water borne diseases, treatment and distribution of water, garbage and sewage disposal, Low cost sanitation, pollution and environmental hazards, role of voluntary organisations and community etc. on protected water supply and environmental sanitation. Features, discussions, quiz programmes etc. form different parts of this series. The synopsis of the various topics of the broadcast was developed in advance by the Socio-Economic Units and distributed to the ICDS centres, libraries, youth clubs and voluntary organisations. The programme which were broadcast in the rural programme hour of AIR, Trivandrum on all Fridays from 6.50 to 7.20 p.m. were relayed by the all radio stations in Kerala. Kerala Water Authority and Canara Bank provided Rs. 20,0000 as prize money for the best listeners. The criteria for judging the best listener was the nature of listener's sustained interest in the programme and the number of his/her correct answers to the queries which were posed at the end of each and every broadcast. A written examination was carried out for selected 40 people and based on that test people were selected for the prizes. Due to high demand from the people this programme has been broadcast twice with changes expressed by the listeners. UNICEF Madras Office and DANIDA, Karnataka took the lead in adapting the topics for similar programmes through AIR. It is worthwhile to mention that a wide spectrum of experts and media persons reacted very positively about this programme.

The News papers, local magazines, doordarsan, display plaques of banks etc have published messages and small write up on various aspects related to water, sanitation, health and environment. Very often discussions and talk has been broadcast through AIR and Doordarsan. Jingles appear in between important programmes.

## **F. Alternate water sources (traditional sources):**

1. Spring development programme: Even though Kerala has good potential of water resources, acute scarcity of water during the summer months



have become a recurrent phenomenon. According to the available statistics only 40 % of the rural population and 70 % of the urban population is provided with protected water supply. A programme on the development of natural springs for supply of drinking water to remote hilly areas of one district has been started by an NGO (Pazhakulam Social Service Society, Adoor) with financial assistance from Royal Netherlands Embassy. Socio-Economic Unit was responsible for supporting the NGO in training, monitoring and management of this activity through community education and participation. Seventy five springs have been developed in the first phase with the active participation and involvement of people in the remote areas of 4 blocks. The experience from this project reveals that through smaller projects like this the per capita cost can be kept below Rs. 100/= and the length of implementation period also can be considerably lowered. The per capita cost of rural water supply scheme for Kerala approved by the GOI is around Rs. 600/=. The usage pattern is 100% and the community has taken the lead in operation, maintenance and management of these seventy five springs. As a result of good response from the community another Dutch NGO has given assistance for the development of another 200 springs for the neighbouring three districts based on the experience gathered from the previous project.

**Improvement of traditional wells:** The Government of Kerala through Kerala water Authority provided Rs. 11 lakhs to the SEU to implement a well improvement programme with community education. So far 125 wells have been renovated and the intention is to complete another 350 wells by January-Feb 1993. Community wells and wells used by more than five families have been given such assistance. Six NGOs are being trained by the SEU in implementing this programme. Three educational classes (one on general aspects including the introduction of the programme, water borne diseases, need for this activity etc) Second class is on construction and participation of people in each step of the programme and the third class is on use and maintenance. The activity provides insight into strategies (and problems faced) in taking up similar activities through out the State. The community contribution varies from 15 to 55% of the cost depending on the total construction cost. The construction design and drainage facilities has been developed in consultation with the community.

### **Protection of traditional water sources through chlorination:**

This programme is carried out by a women's group with support from the SEU. The main objective of the programme is to promote the use of tradition water sources through chlorination and education. More over



good quality bleaching powder is not available at the health centres and shops. Twenty five young women has been selected and trained by the SEU under the auspices of a mahila samajam. The initial supply of bleaching powder and the necessary equipment was provided by the SEU. The group has been packing the bleaching powder in 30 gms. in small attractive packets (one traditional well requires approximately 30 gms bleaching powder for effective chlorination). Each packet costs 75 paise out of which 15 paise will be packing charges and 25 paise will be the allowance for the promoters. The promoters will visit houses in the panchayat and explain the mechanism of chlorination. For demonstrating chlorination the householders have to pay 50 paise in addition to the cost of bleaching powder. Now this activity is ongoing in 12 panchayats. More than 30,000 wells have been chlorinated by this group. Now, the women's group has reached a stage of operating independently. The department of panchayat and health department has recognised them to operate in all the panchayats in one district.

## **G. SUMMARY & CONCLUSION:**

As indicated above it is imperative that while planning and implementing water supply and sanitation programmes people have to be consulted and involved in each stage of the activity. This will help a great deal in identifying and solving problems connected to selection of sites for public tap or latrines, arranging cost recovery, organising effective operation and management, increased use and maintenance of facilities. In the community education, sanitation, monitoring and evaluation, people's participation is quite vital and the crucial element is the designation of appropriate community development workers or organised ward water committees as "change agents" to work with communities before, during and after the planning and installation of any improved system. Nevertheless, it is evident that reliable information on the impact of water supply and sanitation programmes on health in some setting is necessary if sound decisions are to be made.

Special efforts have to be made for problem solving in an area with maximum involvement of the community group and systematically use them to assess their own problems, analyse the problems and identify possible solutions and act to marshal the resources necessary to implement those solutions. More important they must learn to reassess the results or their actions, reanalyse the solutions and modify their actions on a regular basis. It is worthwhile noting that the SEU programme has

succeeded in fostering more intersectoral co-operation and co-ordination between government departments and voluntary organizations. There has been considerable progress in this respect over the past years, and, drawing lessons from these experiences, we have incorporated new approaches while planning the activities for the future. The sanitation programme has attracted attention from many places and this is the only programme in Kerala where the local body is contributing for extending the coverage in the area. Due to consistent commitment and enthusiasm of the community it is possible to provide quality latrines with minimum cost. The usage rate is 96% and the number of children using such facilities are much more than in the other sanitation programme. The strategy developed for the implementation of low cost sanitation programme, community oriented reporting of leaks and faults and community education will provide more insights for planning and implementing integrated health and other rural development programmes. Even though an impact evaluation has not been done scientifically, there are several evidences that the diarrhoeal diseases have been considerably reduced, water consumption pattern has been improved, the proportion of children using the latrine has been increased. More over, the sanitation programme has created a big movement through the panchayat through out the State.

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**Diarrheal diseases and treatment.** Diarrheal diseases are common in developing countries. The prevalence of diarrheal diseases peaks between the ages of 6 and 17 months. This period coincides with weaning, when children have lost the immunological protection of breastmilk but have not yet built their own immunity against disease.

Family background characteristics affect children's chances of having diarrhea. DHS data in Sri Lanka, where diarrheal disease rates are very low, found that the children most likely to have diarrhea live in poor, low status families, where parents are poorly educated and sanitary conditions are worse than usual. Diarrheal diseases tend to be less common among children whose mothers have more education, but the relationship is not as strong as that between child mortality and maternal education, and there is more variation among countries.

More than 100 countries have programs promoting oral rehydration therapy (ORT) for diarrheal dehydration, either with packets of oral rehydration (ORS) or with home-prepared solutions (326). Survey results show that use of ORT varies substantially by country, ranging from lows of 3% of diarrhea cases to a high of 78% of cases. Many more women know about ORS or ORT than actually use them. In most surveyed countries 40% to 60% of mothers with children who had had diarrhea in the two weeks before the survey knew about ORS packets but did not use them (110).



# 7 THE IMPACT OF HEALTH EDUCATION IN AN INCOME GENERATION AND NUTRITION AUGMENTATION PROGRAMME - A CASE STUDY

*K.C. Viswanathan\* - A.Ramalingeswara Rao\*  
- N.C. Appavoo\* A.V. Ssdananda\* and K.Gopalakrishna\**

## ABSTRACT

An income generation and nutrition augmentation scheme by culturing the alga, *Spirulina fusiformis* was launched in two different coastal villages of Chengalpattu MGR District of Tamil Nadu one after another. A focal outbreak of Malaria surfaced in the first village which resulted in the abandonment of the scheme. The Health Education actions gave an entirely different experience in the second village and the same is discussed in this paper.

## INTRODUCTION:

The Guild of Service, Madras a non-Government voluntary organisation started a novel income generation cum nutrition augmentation scheme for the poor women of the fishermen community in Semmencherikuppam in 1988 and later in Madras in 1992. The culture of SPIRULINA algae in open cement tubs gave rise to a focal outbreak of Malaria in Semmencherikuppam resulting in its total discontinuance. The introduction of the usage of mosquito nets during the algal culture right from the training period demonstrated the impact of Health Education in the successful continuance of the scheme. The two different experiences are highlighted here.

## MATERIAL AND METHODS:

### **Semmencherikuppam Experience:**

Semmencherikuppam is a coastal village of Chengalpattu MGR District of Tamil Nadu about 35 Kilometers south of Madras City. The Guild of Service selected a few women from this village and trained them to culture the algae

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in open cement tubs during 1988. The voluntary organisation prepared cement tubs and distributed them at subsidized rates. The organisation supplied the algal seeds free of cost and purchased the harvested algae at Rs. 500/- per Kg. With the training of more women, number of tubs rose from 5 in 1988 to 203 in February 1991. The algal culture involved in keeping the seeded water exposed to sunlight for about 10 to 15 days. A focal outbreak of Malaria was recorded during July 1991 in this village due to profuse breeding of *Anopheles stephensi* mosquito in these tubs. People blamed algal culture for Malaria problem and strongly objected to the algal culture resulting in its total discontinuance even though the Guild of Service attempted to introduce mosquito nets as an intervention. This clearly demonstrated the lack of Health Education component in this scheme, resulting in its failure.

### **Sadras Experience:**

With the experience gained in Semmencherikuppam a similar algal culture scheme was launched in Sadras, another coastal village about 40 Kms south of Semmencherikuppam during September 1992. The usage of Mosquito nets to cover the 77 cement culture tubs to prevent mosquito breeding was introduced in the training programme itself. The women learnt the usage of mosquito nets as part of algal culture procedure. The usage of mosquito nets during active algal culture is being monitored by the village level trainers and the field staff of Public Health Department and their supervisors. The women involved in the scheme are being frequently contacted and mosquito breeding in improperly covered tubs are being demonstrated so as to educate them about the risk of mosquito breeding and malaria transmission. This has created an awareness among the women to ensure careful algal culture without health hazard.

### **RESULTS:**

The Malaria surveillance activities in both Semmencherikuppam and Sadras village are given in the table. The line graph included in the report shows the annual incidence of malaria the time of introduction of the algal culture scheme in these village. The graph clearly indicates a focal outbreak of indigenous vivax malaria in Semmencherikuppam village during 1991. Timely remedial measures like thermal fogging and anti-parasitic measures resulted in the reduction of cases. The declining trend during 1992 in Semmencherikuppam also resulted from the restoration of the eco-system.

## DISCUSSION:

The element of Health Education was missing in Semmencherikuppam resulting in the total discontinuance of the scheme. Even the attempt to introduce mosquito nets during the outbreak as an intervention could not convince the people to continue the algal culture scheme. The success story of Sadras demonstrates that health education as a part of the scheme from the training stage itself has made the scheme viable. Anyone visiting Sadras could see the mosquito nets being used to cover the culture tubs. But he could also see big and small holes in the nets some of them already attended and the rest remain to be mended. From this it is very clear that continued and sustained health education is needed to motivate the women to mend the holes in the mosquito nets as and when noticed to prevent Mosquito breeding.



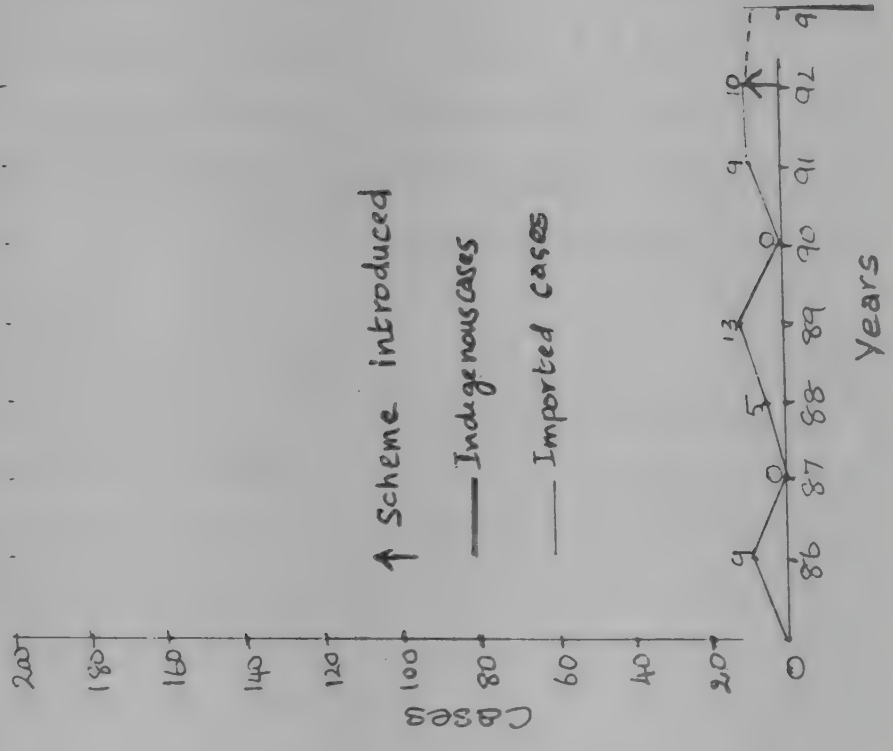
TABLE

## MALARIA SURVEILLANCE IN SEMMENCHERIKUPPAM AND SADRAS

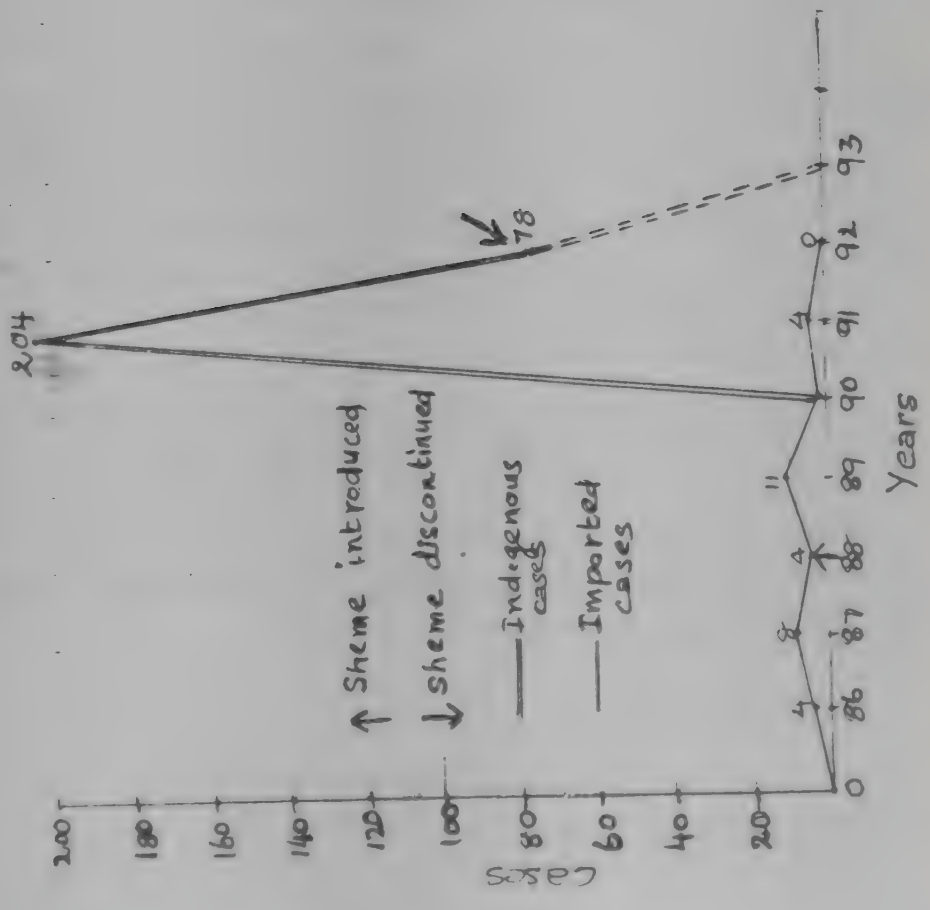
Year	Semmencherikuppam					Sadras						
	Popula- tion	Bs Coll- elec	Malaria Cases	ABER	API	Popula- tion	BS Collec- ted	Malaria Cases		ABER	API	
								Imp	Indi			
1986	862	221	4	-	25.6	4.6	2446	1483	9	-	60.6	3.7
1987	871	186	8	-	21.4	9.2	2508	606	-	-	24.1	-
1988	879	157	4	-	17.9	4.6	2520	689	5	-	27.3	2.0
1989	898	252	11	-	30.0	12.2	2538	2515	13	-	99.00	5.1
1990	901	305	2	-	33.9	2.2	2975	959	-	-	32.2	-
1991	918	684	4	204	76.5	223.3	2975	780	9	-	26.2	3.0
1992	932	540	-	78	57.9	83.7	3066	646	10	-	21.0	3.3
1993	932	41	-	-	-	-	3272	115	8	-	-	-

(Upto May)

# Annual Incidence of malaria Sadras



# Annual Incidence of malaria Semmencherikuppam



# 8 A SUCCESS STORY ON THE STRATEGY OF IMPLEMENTING HEALTH AND IMMUNIZATION PROGRAMMES IN NAZARETHPET VILLAGE WITH COMMUNITY INVOLVEMENT

*Dr. K.N. Kondala Rao*

Ever since independence, our national planners have recognised that involvement of the community is highly essential for the successful implementation of developmental programmes in Agriculture, Family Planning, Adult Education, etc. Keeping with the view, programme for the achievement of our national goal of HEALTH FOR ALL by the 2000, provided for active participation of the people and particularly through involvement of both formal and informal community leaders. Many of the informal leaders in the community may not be directly visible to the programme officers, but they carry considerable influence among the local people. Field experiences have shown that the neglect of the informal and formal leadership results in poor achievement of the targets fixed under health and family welfare programmes. Similarly an understanding of the socio-cultural aspects of the village community is also essential before planning health education programme. The above calls for a study of the community before launching any programmes in health and family welfare. The study should include educational, socio-economic, cultural, religious and superstitious belief of the local community and preparation of a sociogram to map out the powerful groups and influential leaders both formal or informal in the community.

An experiment on the strategy of involvement of community leaders in the planning and implementation of health and family planning programmes was carried out by the author in Nazarethpet village, Chingleput district, Tamil Nadu during 1972-73, while undergoing his supervised field training at the institute on Public Health, Poonamallee as part of the Diploma Course in Health Education. This paper is based on that study.

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# SELECTION OF THE AREA AND PROBLEM:

The Health Unit at the Institute of Public Health Poonamallee offers a variety of services like MATERNITY AND CHILD HEALTH, FAMILY PLANNING, ENVIRONMENTAL SANITATION, CONTROL OF COMMUNICABLE DISEASES, etc. to the people in its area. The Health Unit has also established fully staffed health centre and sub-centres in the area. Health Committees have also been established in many of the villages. After a preliminary study of the four ranges under Health Unit in regard to the functioning of the health committees and programmes, it was decided to take up Nazarethpet subcentre village under Thirumishi main centre, for the study. Though the village had a health committee, its activities were restricted to the maintenance of subcentre and not in community action programmes in health.

The Nazarethpet Health Committee consisted of traditional leaders, most of them being educated rice mill owners. The committee had accumulated a considerable sum of money collected from the rice mill owners. This was considered as an asset for the successful mounting of community actions efforts; the traditional leaders were also very cordial, cooperative and had considerable health awareness. It was therefore decided that a situation should be created under which the leaders could divert their cooperation and resource towards planning and implementing various health programmes essential for the welfare of the people of that village.

It was decided that the Nazarethpet Health Committee should be developed into a model health committee based on sound health education principles and utilised as an example for the formation of health committees in other villages for achieving much greater success in the implementation of health and family planning programmes initiated under the health unit area.

## OBJECTIVES OF THE STUDY:

**General Objectives:-** To improve the health status of the village through active involvement of community leaders.

**Specific objectives:**

1. To study the leadership pattern in the given area.
2. To study the present stage of involvement of the leaders in the various health and family planning programmes.
3. To study the socio-economic conditions of the leaders
4. To conduct a quick K.A.P survey of the leaders
5. To study the favourable and unfavourable conditions for the involvement of the leaders.

6. To form a health committee with the sub-centre health committee members and Panchayat members.
7. To organise an orientation training for the community leaders.
8. To create a cordial relationship between the health personnel and the leaders.
9. To plan and implement atleast one of the programmes of high priority with the active involvement of community leaders.
10. To create a situation in which the community leaders will carry out the remaining programmes with the help and guidance of the Institute of Public Health, Poonamallee.
11. To evaluate the total programmes.

## Planning- Situation Analysis

**Health problems:** To understand the magnitude and epidemiological significance of the health problems in Nazarethpet, a random sample survey of households was conducted with the help of health staff and mass interviewer utilising a schedule prepared for this purpose. Analysis of the survey showed that the following are the health needs of the village.

1. sanitary Latrines.
2. drainage system.
3. protected water supply
4. immunization services
5. family planning education and services.

**Resources:** The survey also showed that the following resource in term of men, money and materials were available.

**Men:** The subcentre was fully staffed. Other resources available included a health committee, Village Panchayat, Community development staff and other local agencies.

**Money:-** Subcentre Health Committee is functioning from 1958, had accumulated funds with them. The Panchayat President was also prepared to invest some amount for the health programmes.

**Materials:** The Institute had at its disposal adequate transport, vaccines and equipments for the immunization programme except Polio, stationery etc. Health educational materials were available in the Institute and also with the State Health Education Bureau.

**Community:** Survey findings and other records revealed that Hindus constituted more than 90% of the population. Rest were Christians and Muslims. Among Hindus, Naicker is the dominant caste and next came

Chettiar, etc., Most of the villagers depended upon agriculture and work in rice mills for their occupation. Since Nazarethpet is only within 13 miles from Madras, the people were literate and not superstitious and had regular urban contacts.

**Leaders:-** A quick K.A.P. survey was done to study the socio economic condition, knowledge and beliefs about health of the health committee members. The village had two influential groups and the decision making pattern vested with these groups. The first group is the mill owners who are also the members of the health committee. The other group consisted of the Panchayat President and members who were not having enough finance at their disposal to invest on health programmes. The two groups were not having cordial relationship.

Nazarethpet village is situated on the Madras to Bangalore trunk road and is only one mile from Poonamallee. So transport facilities were in plenty. There is a post office. All leading Newspapers in English and Tamil were available. The Panchayat had a good public library. There were innovators and early adopters in this village. The village map was prepared with the help of health staff and important land marks were plotted in the map.

## **Detailed Course of Action:**

### **A. Planning Session with the Nazarethpet Health Committee Members:**

A meeting of the health committee was organised on 15 May 1973, and which was attended by the staff of the Public Health Institute. During the meeting the survey findings were shared with the participants. Good discussion followed with the health committee members reaching a consensus on the health needs of the village. The health committee also decided to divert part of unused resources towards meeting the community health needs. They agreed to spend Rs. 500/- towards polio immunization programme for which assistance was not available from the department.

A frank discussion on the relationship between the Health Committee and the Panchayat members followed and it was agreed that both the health committee and panchayat should work in unison. The health committee agreed to involve other agencies' leaders like Panchayat President and members in planning and implementing health programmes. It was also decided at this meeting to organise an one-day orientation training at the Institute of Public Health for all the community leaders of Nazarethpet; meeting also decided that the cement sheet roofing proposed for the maternity assistant quarters be



changed to R.C.C. roofing and requested the engineer to arrange for the preparation of a new plan with the proposed change. The leaders also agreed to construct a separate dispensary block to cater to the health needs other than maternity and inclusive of space for minor surgery, in case the health unit was agreeable to post a qualified doctors at the centre for atleast a few hours a day. The health unit Chief agreed to look into the matter. The meeting also decided to conduct a mass survey to enumerate the children for D.T.P. immunization and also identify the needs under latrine promotion programme.

**Household survey:** A household survey of 276 houses was conducted with the help of sanitary inspector trainees utilising a schedule prepared for this purpose, on 21st May 1973. In addition meetings of the staff were held to plan for the leaders training scheduled for May 24.

**One-Day Orientation Training to the Community Leaders:** About thirty community leaders from the health committee and village panchayat including one lady member, attended the meeting. After a formal welcome and explaining the objective of the meeting, the survey findings from 276 households were shared with the participants. After a preliminary discussion the total group was divided into two sub-groups. The points to be discussed in each group were decided.

Each sub-group elected from among the members a chairman and recorder. Resource persons from the institute staff joined each of the sub-groups to furnish information and guide the discussion, when necessary. After group discussions, each group was taken to the Research-cum-Action Project section for demonstration of the R.C.A.P. latrine. Then the two groups assembled for a common session and presented the group reports before the chairman of the total group. After serious discussions, they arrived at a conclusion and made the following recommendations, with priorities fixed. It was agreed to commence the 1st dose of D.P.T. and Polio in the second week of June.

### **Priorities and Recommendations:**

1. To start D.P.T and Polio 1st dose in 2nd or 3rd week of June 1973.
2. To arrange for the construction of R.C.A.P. latrines.
3. To make proper arrangements for the provision of protected water supply in the village.
4. To provide drainage system in the village with the cooperation of Panchayat.
5. To take up family planning education in the village.

The Health Committee decided to spend Rs. 500/- towards the purchase of polio vaccine for the mass programme. The Panchayat President agreed to

print and supply 1000 D.P.T. and polio cards in Tamil from the Panchayat funds before giving the 1st dose. The Panchayat President also agreed to take up one street initially for construction of drainage after getting approval of the engineer. The Health Committee agreed to sanction some amount from their funds for drainage construction after getting the estimated cost.

## **Participation of Community Leaders in the Immunization Camp:**

During a subsequent meeting, the two main groups, i.e., traditional health committee and panchayat members agreed to share the work load for immunization camp. The leaders distributed the areas among themselves and promised to distribute the D.P.T cards along with health staff. It was also agreed that the parents of the children will be educated, by door to door approach, on the need for immunization, the day prior to the immunisation camp. The same leaders also agreed to accompany the house surgeons door to door for D.P.T. injection.

Even though the health unit wanted the polio immunisation be taken up later, the committee wanted this to be given along with D.P.T compromise was reached to administer polio only for 50 children initially and if the response was favourable the programme will be extended to others. The leaders agreed that the first batch of 50 will be from their families. Immediately the leaders prepared the list of 50 children from their families. An important point made by one of the leaders was that "I gave the names of 5 children, if I missed to get 5 children I will pay a penalty of Rs. 5/-". This was appreciated by other members and they also agreed to the suggestion. **A copy of the eligible children for D.P.T. from each street was given to that street leader for his reference.**

Regarding latrine promotion programme, the Panchayat President asked for more than 20 sets, but the R.C.A.P. Engineer agreed to supply only ten sets initially from the Sriperumbudur workshop.

After the group meeting, a film show was arranged in the premises of Panchayat to educate the people on some of the programmes. Films on Diphtheria and Polio were screened. In between, coloured comics were shown. The films were seen by an audience of 500 people.

**Planning for Polio Immunization:** Convinced of the interest shown by the people, for polio vaccination, the health unit staff made special efforts to procure the vaccine. They also educated themselves by meeting with the concerned people on the actual cost of vaccine, the method of storing and the mode of administration. The health unit laboratory technician and pharmacist were deputed to learn from the Spencers Pharmacist the method of polio



administration. On an appointed day, the author went, to the Spencers for purchase of polio vaccine out of money given by health committee.

**Planning meeting at the health unit:-** The health unit decided to involve the 13 house surgeons under training, along with the health staff for the immunisation camp. They were briefed on various aspects of the programme and allotment of area made to them. They were also given the names of leaders who will be available to help them. The role of each member of the team was clearly defined and a coordinator for each group named. The staff were asked to be ready by 7.00 A.M. on the immunisation day for proceeding to the village. The programme was to start by 8.00 A.M. Vehicles were also allotted to take the staff to the village. The supervision responsibilities was also fixed. A separate group was constituted to supervise the polio programme. The author and one Dr. Sethuraman of the Health Unit agreed to supervise and guide the 4 groups of D.P.T. programme.

**Distribution of Cards and education of households:-** In the evening of 18th June, D.P.T. cards were supplied by the Panchayat President for distribution in each household by the respective leaders. While distributing the cards, the children were examined for contra-indications. The entire family was educated by the leaders and staff on various aspects of the programme. The educated families were advised to read the subject matter printed on the back of the card regarding D.P.T. **The participation of leaders actively in the distributing cards was a good sign for the implementation on 19th.**

**D.T.P. and polio immunisation.** The staff assembled on 19th morning at 7.00A.M. for a brief discussion on the various activities to be carried out on that day. The actual immunisation started in the village by 8.30A.M. with leaders participation. The community leaders distributed among the four staff groups as planned early. The Health Committee President joined the 4th group consisting 4 lady house surgeons and health visitor.

The Panchayat Board President joined the group that administered polio vaccine. On the advise by the Spencers, Madras, the polio drops were administered in one central place only namely the sub-centre.

The author and Dr. Sethuraman went round all the four groups to sort out problems, if any.

By 11.00A.M. three batches of male house surgeons had finished their work. Polio work continued upto 12 Noon. Thereafter the staff returned to the Institute to review the progress of work and the role played by each including the leaders, in the programme. The Assistant Director of Health Services and Family Planning expressed thanks to the house-surgeons and the health staff for the success rate of 93% for D.P.T. and 100% for polio.



**Table showing the number of children to be immunised, those actually immunised and causes for dropouts.**

Group	Target	Achieved	Percentage	Reasons for the dropouts				
				Sick	Absent	DPT already given	UPC	Overage
A	48	40	83	6	2			
B	63	57	91.2	2	2	2		
C	80	71	89	5	2	2		
D	68	52	91	3	-	11	1	1

### Follow-up:

The community leaders were not involved for the follow-up as they were busy with their rice mill business. The follow-up was done by the health staff, by dividing themselves into four groups as was done for the immunisation work.

On the whole, there were no severe complication except some swelling in a few cases and mild rash for one child. Proper advice was given to these cases and the families were reminded on the date for the second dose. During the follow-up, many people were asking as to when their children will be given polio vaccine.

**Extension of Polio to other Children:** Since the Health Committee was interested in meeting the expenditure for the polio programme and the people were interested in the programme, a meeting was organised at the health unit for necessary planning. It was decided that the two Maternity assistants will collect the names of about 120 children whose parents are interested in polio vaccine. The vaccine was to be purchased from Spencer and the date for administration of polio was fixed for 26th June, in the subcentre building.

On 25th June 1973 house visits were made to the houses of 120 children whose names were given by the two maternity assistants. During those visits proper education was imparted to parents regarding what, why and for whom polio oral drops will be administered. The health committee president and members and the panchayat president were also contacted to discuss the programme for 26th June, 1973.

On 26th June 1973 the administration of polio drops commenced at 8.00 A.M. The two maternity assistants, with the help of community leaders, took the responsibility to guide the children to the immunisation centre and distributed sweets to all children who received polio drops. The Chief of the institute of public health was in the Centre during peak hours and gave guidance

to the staff in administering polio successfully. As a co-ordinator supervision of the programme was done by the author. Against a target of 120, the children who turned up for polio drops was 145. The polio drops could however be given to only 130 children. The remaining children could not be covered for want of vaccines.

The experience clearly indicates that the community leaders are prepared to actively involve themselves in the health programme, provided they are properly approached and involved in various phases of programme implementation, starting from the planning phase. On being informed adequately they are also able to appreciate some of the national programme which are of high priority in the government's eyes and absorb them within their own local priorities. The leaders are prepared to shoulder responsibility, thus relieving the health staff some of their work load. With their active involvement, the programme targets could easily be reached. Peoples involvement in health and development of women and children should therefore receive priority attention in the governmental scheme of activities.

## **Rising Demand for Family Planning**

Fertility is falling in developing countries primarily because a growing percentage of married women are using effective family planning. In general, average fertility falls by about one birth for every 15 percentage-point increase in the number of married couples using contraception.

More than 120 million women in the developing world, however, are not using contraception although they say that they want to avoid pregnancy. Meeting this unmet need for contraception is one of the top priorities for family planning programs. Family planning service are reaching a smaller proportion of the potential users in rural areas and among the less educated than in cities and among better educated couples.

*Pop Reports, M.11, 1992*

## 9 COMMUNITY INVOLVEMENT IN MATERNAL AND CHILD HEALTH PROGRAMME, THROUGH HEALTH COMMITTEES - POONAMALLEE EXPERIENCE

*Dr. V. Prithivi M.D., Ms. R. Kamala, M.A., DHE*

**NEED:** Community leadership is a group process with leaders acting as representatives of the group for the accomplishment of certain tasks which the members of the group feel necessary to be achieved for the stability of the group. Leaders are the agents of change and they are also the decision makers on many of the problems that community faces. They are the right channels of communication for the health workers to convey health information both to the leaders and through them to the families in the community. The functional potentiality of the leaders in promoting primary health care and public health programmes cannot be underestimated. The leaders will need training to function as a liaison between the health agency and the community. But who are these leaders and how they can be identified? This is a ticklish problem that a health worker has to face in his job in the field. Hitting at the wrong target always create complications. The programme gets a set back and loses its momentum. To ensure that the programme reaches the people and get their support and participation, it is of paramount interest to locate and identify the local leaders and constitute a truly functional health committee. This however is not an easy task.

**APPROACH:** The location and identification of leaders will vary from situation to situation and from one area to another. The health worker has to develop skills to use different methods in different social situations. Leadership differs from rural to urban areas, as the social structure of the two regions becoming more complex as we move from rural to urban. The leadership in urban areas will usually be localised more in the formal organisations both voluntary and involuntary, that work towards creation of the social, economic and political upsurge among the members of the community.

On the other end of the scale, the leadership in rural area in both formal and informal. The informal leaders are the natural leaders of the area and they exercise a great influence on the people by virtue of their popularity, good

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qualities, humility, socio-economic status, testfulness, ability to negotiate constructive actions, genuine concern for the welfare of people especially mothers and children, able to spare time, decision making ability on a practical basis and **good human relationship skills**. These informal leaders in rural areas play multiple roles simultaneously.

Leadership is the sub-system to the bigger and complex social system and is thus very much co-related to various institutional functions that are to be performed for the stability of a social structure.

Some information on the caste, economic status, land holding occupation, age, education and area influence of the leaders should be known to enable form functional health committee. These are some of the important variables which interact and interplay with each other. Besides information on the cultural values beliefs, attitudes and practices towards primary health programmes should also be collected and analysed.

Emphasis should be laid to understand the felt needs of the people as leadership always grow up with the needs. Some of the important methods that have been tried or are being tried for the location and identification of local leaders at the field study demonstration area of Institute of Public Health are a) discussion methods b) the group observation method c) the socio metric method d) workshop method etc.

In the delivery of primary health care, community participation cannot just come for the asking. Available experiences at Institute of Public Health suggest that such a thing has not happened anywhere, and particularly on a sustained basis. To overcome this, it is essential to have a clear understanding of what community participation is, in health care programmes. Ideally, true or active participation means that the people should be knowledgeable about their own health problems. They should identify the needs, fix priorities and develop action plans for implementing the priority programme, organise and implement programmes, monitor and evaluate the progress periodically and carry out reprogramming based on an analysis of the feedback information. However, under poor social and economic conditions, it may be hard to expect spontaneous participation from the people. People have to be mobilised and encouraged to take greater interest and responsibility for the maintenance of their own health. Initially, there may be passive involvement which has to be gradually and progressively made more active. The formation of a real, viable and functional health committee can help to transform the passive participation into an active one. This is drawn out of the experiences of the institute with various health committees and particularly of Nazarethpettai Health Committee.

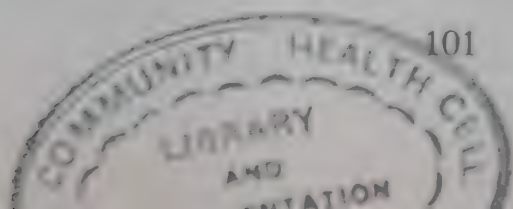
**HEALTH COMMITTEE AND FUNCTIONS:** Institute of Public Health, Poonamallee has instituted functional health committees especially in

those villages where main and sub MCM centres are located. These Health Committees act as a 'Key communication link' between the community and the health agency. All preventive service measures to be implemented in their respective villages are explained to the active health committee members by the staff of Institute, so as to elicit the most desired community participation through the leaders. Besides helping their own people to avail the preventive service measures available at both main and subcentre level, these health committee members play active role in

- a. proper dissemination of health information
- b. organising community's efforts during health camp and campaigns
- c. Facilitating in organising health functions, nutrition weeks, well baby shows etc.
- d. Proper implementation of nutrition's noon meal programme
- e. If economy permits, enriching the MCM centre by way of supplying needed materials.
- f. helping the health staff in sanitary measures during village fairs and festivals.
- g. effecting appropriate preliminary arrangements for mass and group health educational sessions that are being organised regularly throughout the calendar year.
- h. to render necessary help in the health appraisal of preschool, school and general public
- i. to organise the community for anticipatory anticholera inoculation and rendering help to health staff to provide protected water.
- j. to act as a 'source credible person' for motivating people to adopt family welfare measures and sanitary toilet.

Thus a health committee is a group of people belonging to the same entity and having a common perception of collective needs and priorities of the people and abilities to assume responsibility for decisions made within the community.

Experiences within the Institute of Public Health have clearly demonstrated that health committee participation can significantly contribute towards bringing about desired health development. It increases understanding of the user perceptive in the management of health. The members chosen by the community are appropriately trained. They act as front line workers in direct contact with the beneficiaries. The participation of the community also renders the services more accessible and acceptable to the people. It promotes and strengthens self-reliance in matters of delivery of health services. The health committee can mobilise human, financial and material resources to supplement



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the resources being provided by the Government and non-governmental agencies and can thus reduce its dependence on bureaucratic structure. Participation also develops a sense of responsibility within the community. Since the indigenous knowledge and local resources are utilised, it can bring down the cost of health. For the organisation of preventive and promotive aspects of primary health care, health committee members are the main agents. Various non-health sectors contribute significantly to health development. The interaction and coordination of different sectoral activities necessary for making an adequate and sustained impact on health can be brought about only at the community level and through community actions and organisation. Community participation generated by the health committee also serves as a catalyst for future developmental efforts.

### **BRIEF PROFILE ON NAZARETHPETTAI HEALTH COMMITTEE:**

**Building:** The present building is built on 8 grounds donated by Varadappa Mudaliar of Nazarethpettai. It is managed by health committee members under the president-ship of late Thiru Chellapa Chettiar with a local donation of Rs. 17,626/- and with the help of Madras City Police. Foundation stone was laid by late Thiru Kamaraj, Emeritus Chief Minister of Madras on 16.8.1957 and opened by Thiru Pandit Govinda Vallaba Pant and Thiru M. Bakthavatsalam (who later on became Chief Minister of Tamil Nadu) on 22.12.1958.

**Contribution towards maintenance:** Most of the people, in the past, at Nazarethpettai was engaged actively in whole sale business of rice. During those days bullock carts were used for transporting paddy from the fields to the rice mills and then to the retailers, and it was customary on the part of the cart owners to donate "8 annas" towards the maintenance of MGH Centre. As modern transport facilities became more accessible and easily available, the scheme had its natural death. This does not mean that the Pettai community has stopped their financial assistance to MCH centre. They are helping to enrich the MCH centre continuously.

**Membership:** There are sixteen members in the health committee which is headed by a famous social worker, who is also the daughter of one of the (late) Chief ministers. The members are influential people in the village.

The following functions are performed by the committee:-

1. Periodical supply of linen and equipments to MCH centres
2. Donation of child frock for every baby born in MCH centre
3. Conducting informal meetings among themselves with occasional presence of health team members to discuss about health problems and how best the committee could contribute for their solution.



4. Acting as key communicators for all preventive service measures rendered by Institute of Public Health especially for MCH, Family Welfare and promotion of Sanitary Latrines.
5. Mobilising local resources in terms of men, material and finance for special health functions such as camps, and campaigns in family welfare, eye care, dental camps, leprosy camps, campaign against dirt and disease, nutrition weeks, well baby shows, medical camps etc.
6. Helping in the organisation of 'cafeteria approach in health education'.
7. Organising the local community for their active participation.
8. Working along with the health teams of institute of public health in organising service, research and training activities of institute and acting as liaison between the people and health care providers.

Pettai Health Committee, from its very inception way back in 1957, has been rendering real help to their community with the technical expertise at Institute of Public Health. The committee functions on a democratic basis. The committee used to orient institutional visitors and trainees about how best a Village Health Committee can function and enlist genuine community participation. Some of the outstanding examples of such constructive endeavors are:

- Health committee Pettai organised development week and rural medical camps commencing from 19.4.1980. Many important dignitaries participated.
- I.U.H.E. selected Pettai Health Committee for field visit during their first conference on mother and child health care during 1985. All participants visited Pettai and interacted with the committee members who had taken great pains to gather at the M&CM Centre inspite of heavy rain and thunderstorm.

**FUTURE PLANS:** Late Mr. Chellappa Chettiyar has donated 5 grounds with an intention of constructing a marriage hall, and utilise the rental proceeds for the maintenance of M&CH centre. Due to financial constraints the building is only a half a way through. Discussion within the committee has resulted in adopting an innovative approach for completion of construction by lending the building on a fixed rent to a businessman who will invest the capital required for its completion. The rent is to be used for M&CH care. The idea is being actively pursued.

## **Lessons learnt:**

Health information and health education represent 'the two wheels of the same chariot pushing toward the Health For all Goals. People have a right to information. But It's mere disseminations is not enough. Health cannot be imposed, it has to be attained. Health Educators are slowly changing their

emphasis from “how best to teach facts” to awaken the need in the community to take the responsibility for one’s own health and act accordingly. Successful health education efforts involve a continuous process of learning, relearning, sometimes even “unlearning”.

The life styles are major contributory factors to many diseases and changing behaviour pattern is becoming more complex and difficult to define. Many obviously harmful behaviors have become part and parcel of everyday life and need to be altered if not dropped altogether; A task easier said than done.

All over the world, aggressive advertising had led people to associate smoking with status, glamour and freedom. It is only recently that they are revising their views. In a number of countries, such a dent has already been made. Smoking is actually on the increase in developing countries. A truism that both health and health care are social phenomena which influence, and are in turn influenced by their social, Physical and economic contexts.

For example, people may know what occupational hazards they face but lack the political clout to overcome them. People may know the importance of sanitary toilet but may be handicapped in their acceptance due to water scarcity, inadequate space and mainly due to financial constraint.

Successful health educators do not blame the people if they do not behave in a health way. Rather they concentrate on:-

- Talking to the people and listening to their problems.
- Thinking of the behaviour or actions that could cause, cure and prevent the problems.
- Finding reasons for people’s behaviour.
- Helping people to see the reasons for their actions and health problems.
- Asking people to present their own ideas for solving the problem.
- Helping people to look at their ideas so that they can see which are the most useful and simplest to put into practice.
- Encouraging people to chose the idea best suited to their circumstances.

Education for health should not be a “classroom exercise”, rather it must start from where the people are and health committees play a vital role in helping the health educators realise and build upon on the self-care behaviour pattern which already exists in the community, besides communicating with people in their natural environments. Three particularly important learning environments are the home, schools and workplace. No single medium is adequate. Mass media with a judicious combination of group based community education and participation will have to be used. Indigenous media are an important resource and it may worthwhile to work out viable ways of using them

than to invest in sophisticated media equipment which may become absolute, difficult to service and expensive to maintain.

The time has come for a new kind of dialogue and action between health providers and the people. Information and education for health is the basic tool to begin this dialogue.

The role of information and education for health through functional health committees must be understood and recognised in the context of:

- Developing a value for health.

- DEVELOPMENT OF LOCAL MECHANISMS FOR PEOPLE to express their views on the governments health policy and to take an active part in the planning and delivery of health programmes, including health education.

- Making decision-makers and health services providers understand people's health cultures and values and work towards achieving genuine community participation in programme planning and implementation.

The Institute of Public Health, Poonamallee is on the move in the above directions, thanks to the lessons learnt out of their working with Pettai health committee.

**Child Nutrition.** By one recent estimate, 177 million children in the developing world are malnourished—about one child in every three under age 5 (326). Although malnutrition is not easily defined, one common indicator of the extent of chronic malnutrition is the percentage of children who are stunted—that is, short of their age (326).

Children are considered stunted if their height is two standard deviations or more below the median of the WHO international reference population (216).

Household conditions play an important role in determining children's nutritional status. Bicego and Boerma report that children's nutritional status, as measured by the percentage stunted, is closely linked to their mother's level of education (153). A study of Elisabeth Sommerfelt found that in most countries stunting is significantly more common among children of uneducated mothers, as well as those living in rural areas, living in households without toilets or with few household possessions, or born less than two years after a sibling (231).



# 10 PARTICIPATORY HEALTH EDUCATION TECHNIQUES FOR BETTER WATER SUPPLY AND SANITATION PROGRAMMES

*Dr. S. Ponnuraj*

Health Education is essential for the success of any health programme and it plays a vital role in the promotion of Rural Sanitation Programme. However, hygiene education through mass media requires more resources in men, money and communication materials which is prohibitively costly. Therefore, efforts must be made at various levels to evolve, as an alternative, a cost effective health education techniques.

Several health education techniques of educating women are available. But they have often failed to penetrate the changing attitudes and hygiene behaviour of the primary guardians (Women) of the household hygiene to the desired level. Participatory Health Education Technique (PET) may be a viable alternative technique / method in which an extension educator can accommodate 30 to 35 people and it could easily be implemented in a village.

While attempting change to the attitude and behaviour of the village woman PET increases their involvement in the learning process easily, and once awareness is created, change may come quickly. This has been tested successfully in two service villages of our Institute where women were able to identify the problems associated with disposal of waste water arising from their household activities.

## METHODOLOGY

On the first day of our hygiene education, village women were asked to locate the houses with problems of household waste water. The women, numbering thirty, came out spontaneously and went round the village and identified and located thirty seven houses having problems of water stagnation, mosquito-breeding, bad odour and lack of place to play for their children near their dwelling places. In the afternoon, the women were asked to present the problems. They readily did it. At the end of the session, the women were asked to ruminate over the problem and come up with solutions the next day.

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On the second day they came with the determination of disposing of waste water coming out of their houses but they failed to identify the appropriate technology for the problem. At this stage, the extension worker demonstrated the laying of a soak pit near a public bore well. The “on the spot demonstration” helped the women to know how simple soak pit (technology) is the solution for their problem. They started discussing among themselves how and where to collect simple materials like pebbles for the construction of soak pits for their own houses.

On the third day, twentytwo women came forward and told our extension worker that they had collected materials for laying of soak pits beside their houses. The extension worker guided them in digging the pit and in constructing the soak pits. After seeing the success of the programme, the remaining women came forward to have their own soak pits. At this stage, the extension worker told the group to construct them with the help of now experienced women’s group and withdrew from the village. Two days later the worker went and found that women who had participated in the first phase of the construction had been acting as the change / link agents between the rest of the women and adoption of the technology.

Participatory Health Education Method, whether it is used by the extension worker or by the village women, allows learning to occur outside the confines of the traditional pedagogic methods. Such learning process could also be improved by interactive activities like folk-songs, role-play etc. Synergistic activities can easily enable the village community to identify the problems and resources themselves. Once they identify their problems through participation, they can fix goals and achieve them collectively or individually.

## **CREATING PARTICIPATORY AWARENESS THROUGH SCHOOL CHILDREN**

Another way of creating awareness of rural sanitation in villages is by involving school children through PET. Despite the fact that the majority in Indian rural households are below twenty years of age, they are rarely taught hygiene education for health status. If behaviour is not adopted by the children and youth, changes in the health status of the nation will be difficult to achieve and sustain. Therefore an effort was made to include children in hygiene education through PET.

## **METHODOLOGY**

Seventh and eighth Grade students of on of the schools of our service village were asked to depict graphically the sanitation and water supply

facilities and the sanitation problems in and around their houses on sheets of paper which we provided. The request created an enthusiasm among the students and they moved out to locate the places with problems. They came back and mapped out the facilities and problems in the village (see map). The problems were: Damaged Community latrines, piggaries, broken handpumps, stagnation of water, open-air defecation and mosquito-breeding sites. The resources included: Household latrines, overhead tanks, school latrines and urinals and health centre. Later the extension worker explained the sanitary conditions to the students with their own maps. Positive awareness was created among the students at the least cost and with the maximum participation. In the afternoon, the positive awareness was utilized as medium for education the community. The students were asked to go and visit the households to tell the people the hazards of in sanitary condition of their village and importance of having household latrines. The techniques helped us to construct 16 household latrines in the village.

## **SUSTAINABILITY:**

PET is not an end itself to solve every problem in the village but it is a beginning in educating the villagers to appreciate, appraise and identify the problems, resources and techniques by themselves. Therefore, the next step would be group discussion to plan and take decision about intervention techniques to solve the problems. Then only we can say that the learning process has been completed (Model).

RAPID APPRAISAL THRO' ONE OR TWO VISITS

SELECT ONE PROBLEM

PARTICIPATORY CUM DIRECT OBSERVATION OF THE PROBLEM

SELECT SOLUTION BY PARTICIPATION

COLLECTIVE INVTERVENTION FOR COMMON PROBLEM

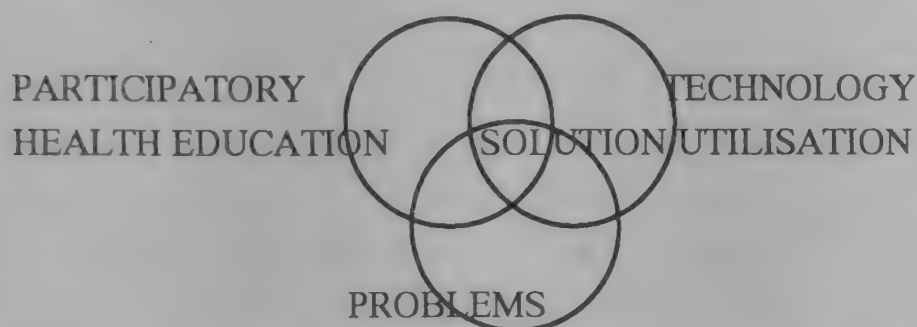
REPEAT FOR SUSTAINABILITY

## **CONCLUSION:**

Our experiences in the two villages **proved that by integrating Participatory Health Education Technique with Sanitation Technology** as a package made the community accept and **adopt new technologies and develop a positive behaviour towards sanitation**. Also we found that the method is cost-effective in improving the health status of the women and children in a



rural set-up. PET Method has raised the demand for disposing of the waste water hygienically and promoted household latrine programme in the villages.



PET is a cost effective method and could easily be tried with as it involves less resources in finance and is also serves as a means through which the extension worker could easily reach the community.

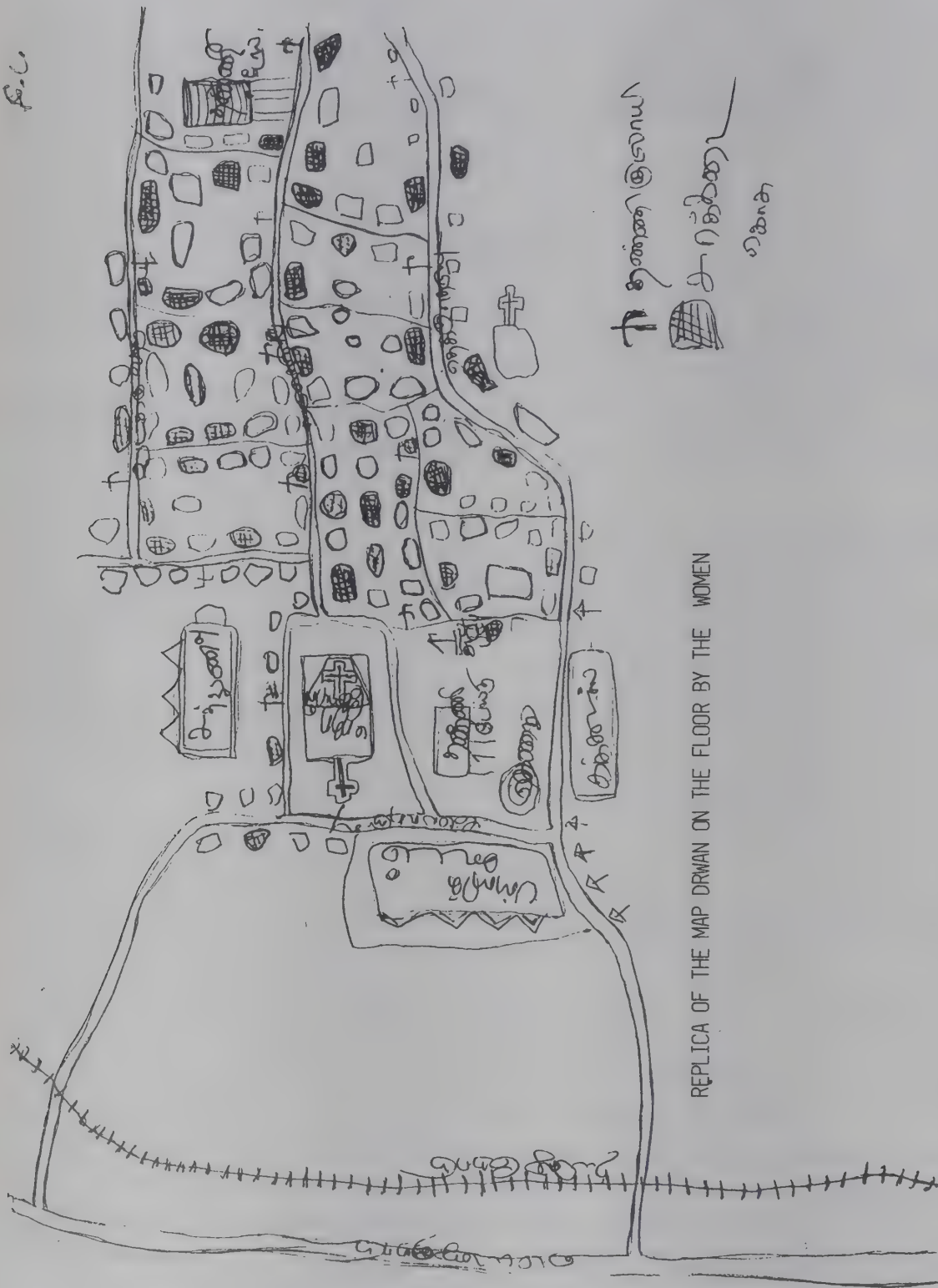
Further, PET can be used in other health (education) programmes too as effectively as it was used in promoting Sanitation programmes.

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Children's chances of survival have improved in developing countries, but child mortality remains much higher than in the developed world. Among surveyed countries mortality before age 5 ranges from 250 deaths per 1,000 births in Mali to 35 per 1,000 in Colombia and Sri Lanka.

*Pop. Reports. M-11 (1992)*



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✚ ഗുണഭോക്താക്കൾ  
 ✚ ഗവണ്മെന്റ്  
 ഹിസ്റ്ററി

REPLICA OF THE MAP DRAWN ON THE FLOOR BY THE WOMEN

சாகரதாறு நிலையம்



MAP DRAWN BY THE SCHOOL CHILDREN



# 11 GANDHIGRAM EXPERIENCE - COMMUNITY PARTICIPATION IN SANITATION PROGRAMME

*P. Shanmugam\* and V. Kandasamy\*\**

## INTRODUCTION

Gandhigram Institute of Rural Health and Family Welfare Trust has been engaged for the past three decades in training, research and field demonstration in rural health and family welfare. The Institute demonstrated the community involvement and participation in health and family welfare programmes in Authoor and neighbouring blocks. The performances of the programmes were enhanced with the active participation of community leaders (Both men and women).

The Institute experimented a sanitation programme also with community participation. Sanitation is a way of life. Sanitation of the environment is part of the way of the community living. Change in the environment involves changes in attitude and behaviour as well as provision of facilities. Research cum Action project at Poonamalle (Madras) Nagafgarh (Delhi) and Singur (Calcutta) during late sixties investigated the sociological factors influencing the knowledge, attitude and behaviour of preventive and promotive measures, related to personal hygiene and sanitation and developed a pour-flush, water-seal latrine with leach pit. Individual household latrines were accepted by 10% of the households and they were confined mainly to higher socio economic groups. The acceptance and use of latrines in the rural areas and slums of cities are still less than 15% of the households.

Proper disposal of waste water is another essential component of sanitation. The water stagnation results in pools and ponds along the street and poses public health problems like sub-soil pollution, contamination of drinking water in wells and also mosquito breeding. Lack of community participation in taking joint action, lack of expertise for solving the problem and inadequate financial resources are the major reasons for the improper disposal of waste water.

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Another important community health problem is that of refuse collection and disposal. To ensure proper maintenance of the existing drainage system in the community, proper collection and disposal of refuse is necessary.

Experiences gained over the years in water supply and sanitation projects show that best results are obtained only when communities participate in the planning and implementation of projects along with other sectors.

“Community participation is an educational and empowering process in which the people, in partnership with those who are able to assist them, identify the problems and the needs and increasingly assume responsibilities themselves to plan, manage, control and assess the collective actions that are proved necessary”.

### **Sanitation Programme in Chinnalapatti:**

Chinnalapatti is a big village with 30,000 population situated about 2 kilometers from the Institute. Many programmes were organised in this village. GANDHIGRAM had initiated the construction of house hold latrine programme from 1961.

One thousand and two hundred latrines were constructed with concrete pans (RCAP Model). The remaining houses were unable to afford to have household latrines, due to want of space and money. The experience gained in the recent years, indicate the growing awareness in the people about the association between insanitation and diseases. There is also a growing need to use latrines for the sake of privacy, particularly for women. Moreover with the rapid increase of construction of houses, there is a sharp decline in the availability of open space for defaecation. Hence people themselves were expressing the desire for community latrines.

A Community managed scheme of toilet facilities along with bath houses on ‘pay and use’ basis in Chinnalapatti village will ensure a revolving financial resources for utilisation and upkeep of the toilet facilities. This programme also proposed to find out the impact of sanitary latrines and bath houses on the health status of the community.

“Devanga Narpani Manram” a youth organisation discussed with the Institute about this programme. Various agencies were contacted for financial assistance. Dr. John Gill Director, Health Service Division, IDRC., Canada visited the Institute during 1981. During his visit the Institute facilitated the youth organization and leaders of Chinnalapatti to meet and discuss with him about the community latrine complexes. Later the project proposal was prepared by the Institute, IDRC, Canada and youth organisation.

This programme was a pioneering attempt to demonstrate community participation in a rural area, which will be taken by the Governments in replicating the approach in other areas. This project involved planning construction, maintenance and evaluation of community toilets with bath facilities, improved waste water disposal through upgraded maintenance of drains at various levels and provision of oxidation pond/sullage farm, improved refuse collection and disposal and health education to improve practices related to latrine usage, waste water disposal, personal hygiene and refuse collection and disposal.

This programme was conducted between 1982-1987. Sanitary facilities were provided with 10 toilet complexes having 160 latrine seats and 40 bathrooms with washing facilities. Each complex is provided with a compound, well with electric motor and pump and water storage tank. Provision of 150 dustbins and one rubbish cart, constriction of drainage were the other facilities provided in this programme.

The Important philosophy and guiding principles followed in the programme in all stages and the programme strategy was as follows.

- a. Formation of Area Sanitation committees and defining their roles.
- b. Evolving a comprehensive plan.
- c. Deciding accounting procedures.
- d. Process of selection of sites, procuring lands for construction of toilets and bath-houses, water supply and waste water disposal and maintenance.
- e. Health Education of the community through leaders, mothers, youth and programme personnel.
- f. Evaluation of the programme impact on morbidity and mortality patterns.

This programme provided all opportunities for the community to plan and important role in decision making process through the Action Committee and Area Committee.

The action committee constituted members from Devangar Narpani Mandram (youth Organization), Executive Officer of town panchayat, Sanitary Inspector, Medical Officers of Primary Health Centre, Chinnalapatti and Institute staff and functioned at village level. The role responsibilities of the committee were:

- Selection of sites for construction of units and the procurement of material
- Assisting the project staff in the formation of area committee.



- Assisting the project staff in conducting educational activities.
- Guiding the area committees in maintenance of Toilet complexes and follow up.

The area Sanitation Committees were constituted by utilising the existing infrastructure. The village has street-wise/area wise caste group committees for the celebration of festivals and to carry out other religious activities. These committees exist for 10 segments of the village.

The functions of these committees are as follows:

- Providing free land for the construction of toilet complexes and arrange for
- Construction of toilet complexes
- Collection of money from individuals in families for using the facilities.
- Maintenance of the Toilet complexes
- Participation in educational activities and
- Helping the project staff in all other activities.

Action Committee decided upon the criteria/norms and the same were put into action by Area Sanitation Committee. For example, Action Committee decided criteria for selection of sites for construction and the same was followed by area sanitation committees. Action committee planned to take up construction work in a phased manner since there was severe drought condition. Number of latrine seats and bath were decided by the action committee based on the population of the area.

The use of tokens for users and later the card system was decided by the action committee and area sanitation committees. The accounting procedures, methodology of receiving advance amount and reimbursement for construction work etc. Were decided by the committees. The community was taking important role in planning, construction, maintenance evaluation and follow-up of the programme.

## **Mobilization of Resources:**

According to a WHO document, among all other resources the human resource is the untapped resource. The available resources within the community like primary Health Centre and sub-centres were made available for this programme. Other resources like the local medical practitioners, Devanga Narpani Mandram and other caste organisations were involved in the programme activities. The land for construction of toilet complexes were made available through community contribution. The available resources like

laboratory, library media in the Institute and other agencies such as public health laboratory, national Environmental Engineering Research Institute (NEERI) and Anna University at Madras were also utilised.

### **Intersectoral Co-ordination:**

One reason for the successful functioning of this project was the co-ordination among the Institute and other agencies like Khadi and Village Industries Commission (KVIC) Town Panchayat, Kasturba Hospital, Primary Health Centre etc. KVIC supplied four bio-gas plants at subsidised cost for two units. The town panchayat was involved in giving technical advice for construction of toilets, drainage and maintenance. Data on faecal borne diseases and skin diseases were collected from Kasturba Hospital Candhigram and primary Health Centre, Chinnalapatti periodically.

### **Training Programmes:**

Orientation programmes were conducted for the action committee members in the beginning of the study to discuss on following aspects.

1. Objectives of the study
2. Activities to be carried out
3. Methodologies/strategies to be followed
4. Formation of area committees
5. Roles of action committee and area committees
6. Health Education programmes.

The action committee members participated in all the area sanitation committee meetings.

The area Sanitation Committee members were oriented on the project objectives, activities, mobilization of resources, sanitary practices, their role in the programme etc.

In addition to this orientation, 3 leaders training camps for about 300 men and women leaders representing all streetes and all caste groups were conducted.

Fifty Sanitary staff working in town panchayat were given one day training programme about the programme objectives, excreta disposal, sullage disposal, refuse disposal, personal hygiene, use of public toilets and their role in the programme etc., with the help of the Executive Officer and Sanitary Inspector of the town panchayat.

The attendants (men and women) from all the toilet complexes were trained for 2 days by the project sanitary Inspector about personal hygiene, cleanliness of latrine seats, bath rooms and the surroundings. They were also explained about collection and disposal of sullage water, development of banana/coconut garden, collection and disposal of rubbish inside the campus and personal hygiene practices.

The training Programme was followed up through on the spot guidance by the programme personnel.

## **Health Education:**

Health Education is integrated with the programme activities. The responsibility of health education is shared by the programme personnel including town panchayat officials and PHC staff and leaders of the village.

Mass educational activities were conducted to create awareness about the service facilities provided in the programme and strengthen strong social support for the project activities. 26 film shows were conducted in different areas of the village on sanitation, personal hygiene etc., Slides were projected in the two cinema houses about the facilities available in the community toilet complexes. 24 mass meetings were conducted to create awareness among the people on construction and maintenance of the units.

Both formal and informal group meeting/discussions were conducted every week in different places. Informal discussions were conducted at public gathering places like tea-shop, chavadi, barber shops etc. Houses of influential leaders were also utilised for conducting the meetings/discussions. Streetwise group meetings were conducted for strengthening group support and clearing the misconception about the toilets.. Need and importance of using the toilets regularly, use of card/token system and problems related with maintenance of toilet complex were discussed. Area Committee members were involved in group meeting and group discussions. Separate sessions were conducted for men and women.

The programme personnel made home visits to discuss with the families regarding the usage and maintenance toilet complexes, keeping the homes clean, collection and disposal of refuse and keeping the drains clean. Family members were requested to express their difficulties/inconveniences in using the bath houses and latrines. Necessary clarifications were given to keep up their interest in using the facilities. Audio visual aids such as flash cards and charts were used to communicate effectively and facilitate easy understanding.



## **The following aids were used with different education approaches**

- |                        |                                                                                                                                         |
|------------------------|-----------------------------------------------------------------------------------------------------------------------------------------|
| 1. Mass approach       | - Public hoardings<br>- Information boards<br>- Film shows<br>- Slides in the cinema halls<br>- Leaflets & books lets<br>- Posters etc. |
| 2. Group Approach      | - Flash cards<br>- Flannel graph<br>- Specimens<br>- Models<br>- Charts                                                                 |
| 3. Individual approach | - Picture cards<br>- Specimens<br>- leaflets<br>- Booklets                                                                              |

## **Findings and Recommendations**

1. Users of public toilets and house hold latrines increased from 24% to 34%. The substantial increase in the usage of project latrines and household latrines was mainly attributed to the provision of public latrines with all facilities and intensive health education.
2. It was found that there was improved adoption of personal hygiene among the population between baseline survey and final evaluation survey., For example, the habit of taking bath every day among the people was increased from 76% to 79% between baseline survey and final evaluation survey. Similarly 90% of the people had the habit of throwing the rubbish outside the house during baseline survey. This habit was changed considerably and most of them (nearly 70%) dispose the rubbish only in the dust bins.
3. The construction cost for each sanitary toilet varies from Rs.3,698/- to Rs.5835/- It was less in the earlier construction than the recent construction. Delay during construction also increase the cost the unit. Supervision of programme personnel and area committee leaders helped to reduce the wastage of resources. To reduce the cost still low, bulk purchase of materials and use of locally available materials are recommended.

4. Community participation was found appreciable in the implementation of this project. They have donated the required land for the construction of project latrines and the entire completion of construction work was done only by the community. Each Toilet complex is maintained by an area committee which is also looking after the income and expenditure of the unit. All the complexes are maintained with self sufficiency. The income from these complexes are sufficient and paid as salary for the workers, Electricity fee, minor repair etc., even after 5 Years. Few complexes are getting additional income from coconut trees grown in side the toilet complex by using the waste water.
5. Two units were provided with bio-gas plants. The toilet seats were connected to these plants. The gas produced was used for heating water for bath purposes. The community was not accepting the use of gas for cooking purposes.
6. It was found that incidence rates of faecal borne diseases and skin disease have decreased sharply between baseline survey and final evaluation survey. For example, incidence rate of diarrhoea and dysentery was reduced from 9.62 to 1.6. Similarly general skin diseases have declined from 10.91 to 1.04. Similar declining trends was also observed an overall declining trend in the incidence of faecal borne diseases and skin diseases.
7. Repair of motor pumps (jet motors) and water scarcity are the main problems impeding the successful functioning of toilet units. Care should be taken to instal powerful motors (other than jet motors and ensure adequate water for toilets and bathrooms)
8. Students of Health Education and sanitation gained field experiences through this project. They conducted health education programmes and observed the functioning of dispersion trench, leach pit, septic tank, sullage farm, drains etc., many short term and long term trainees also got opportunities to observe the functioning of toilet units through community participation.

The Chinnalapatti experience of providing “pay and use” of community latrine, is very satisfactory. Health Education - in a sustained manner and the involvement of community at large has evinced a lot of “ demand generation from the other areas of this town and also the nearby rural villages.” This experience has been duplicated in 10 small villages with financial assistance from CAPART.

# 12 PEOPLE'S PARTICIPATION IN LOW-COST SANITATION PROGRAMME STRATEGIES AND STEPS INVOLVED

*Dr. K. Balachandra Kurup\**

## BACKGROUND

1. Eventhough Kerala remains in the forefront in health status by any comparable and measurable standards, a high morbidity, low mortality syndrome is very unique in the State. This is mainly due to lack of sanitary facilities, polluted water and unhygienic practices. Sanitation programme which started in India and Kerala since 1943, has yet to make much headway, need attention to increase the coverage and proper use and maintenance of the available facilities. Investments in sanitation and water supply result in high economic, social and environmental returns. However, the returns depend on the effective utilisation and management of sanitation facilities and water supply systems. Even in a highly literate society like Kerala the situation is not as encouraging as it should be. In the rural sanitation field, Kerala has historically an important place beginning in the 1950s. However, the state lacks a clearcut strategy and management style to implement community-based, low-cost sanitation programme. The government departments, such as PHED, rural development and health services were entrusted with this responsibility but none of the departments were able to develop a practical and continuing operational plan.
2. The main institutions involved in the provision of low-cost sanitation (latrines) in Kerala are:
  - (1) Rural Development Department
  - (2) Municipalities,
  - (3) Panchayats,
  - (4) Departments of Fisheries
  - (5) Departments of Housing,

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- (6) Tribal Welfare Department,
- (7) Department of Scheduled Caste,
- (8) Social Welfare Department,
- (9) Co-operative Bank,
- (10) Kerala Water Authority
- (11) the Socio-Economic Units in association with the KWA and governments of Netherlands and Denmark,
- (12) People's Action for Development PAD/CAPART Kerala through NGO's and women's organizations.

The last three apparently have the largest completed construction efforts.

However, no reliable data is available on the magnitude of their operation, coverage, strategy followed and use of sanitation facilities constructed under various programme. This paper examines the strategy used for implementing the Socio-Economic Unit's programme for low-cost sanitation through Panchayats and local organizations. This strategy operates somewhat differently from that of the other larger programmes.

3. By way of background, it should be noted that a panchayat, in Kerala, has an average population of about 25,000 people. These people do not live in clustered villages but live along roads and paths throughout the panchayat. In the areas where the Socio-Economic Units work, the population density for these rural areas ranges from about 900 people per square kilometer to 2000 people per sq.km. Each panchayat is divided for administrative purposes into wards whose population averages about 2500 people. The panchayat is active and is composed of an elected panchayat president and elected ward members.

## PILOT PROGRAMME:

4. In 1987 a small number of double-pit, pour flush latrines were constructed by the Socio-Economic Unit based in Calicut. Subsequently, it was decided to launch the programme in the other two Units that had just been set up in 1988. Faced with the challenge of constructing large numbers of latrines (currently the goal is approximately 50,000), it was not obvious which management and administrative strategies should be developed, particularly the institutional linkages.
5. The challenge, as defined in 1989, was to provide as many households as possible with proper sanitation but in such a way that the beneficiaries understand and appreciate the facility and use it properly. This meant, in practical terms, not only construction but mobilization and motivation of

the beneficiaries; arranging for involvement of local groups and finally, construction of technically sound latrines at low cost. The given latrine design was the double pit pour-flush latrine with squatting pan of steep gradient and trap with a 20mm water seal. Since most programmes in Kerala include a complete superstructure. It was also included in the programme. The major challenge than, was not technical, but was managerial and administrative.

6. Therefore, it was decided to have there pilot programmes to try out different institutional arrangements for implementation of the programme. The three programme which were carried out in 1989 compared planning and implementation with:
  - Voluntary and semi-governmental institutions (three different institutions with sufficient experience and manpower to manage and construct 500 latrines each in three different panchayats);
  - through the panchayat (local government) and voluntary Ward Water Committee. The Ward Water Committee includes members of active local institutions such as the Health Department, ICDS, schools, youth and women's organizations (tried out in two panchayats, 500 latrines each);
  - by the Socio - Economic Units directly (two panchayats, 500 to 1,000 latrines each).
7. In all cases, the double-pit, pour flush latrine was built with superstructure have in 20% financial contribution from beneficiary plus digging of pit. This is a poverty-oriented programme. All beneficiary families were to be below the poverty line, with selection based on certain commonly-agreed criteria.
8. A Comparison of out comes of these three pilot programmes showed the importance of education, community mobilization and follow-up. The pilot programme carried out through the local government with Ward Water Communities proved most satisfactory. The work of the voluntary and semi-government institutions was weaker in education and in obtaining commitment of families and community. The work directly implemented by the Socio-Economic Units require a level of manpower that could probably not be sustained in a larger programme.
9. The pilot experience also showed the need for adequate time (at least 3 months) before implementation of education and mobilization activities; need to involve health department staff and members of other institutions active locally; the need for follow-up monitoring for at least a year after construction. This has become the model for the programme that is

currently being implemented. Provision of effective sanitation for large number of families requires mobilization of already present organizational resources— not to do every thing our selves but to work through local institutions. The best way to mobilize these is through the panchayat, the Ward Water Committee and the Socio-Economic Units working together.

## **CURRENT PROGRAMME - 75% SUBSIDY:**

10. The programme has three components, of which construction is only one. The main elements of the programme are community and beneficiary motivation and participation, education / communication for improved sanitation and, lastly, construction. Each element is equally important.
11. Each of these three elements is described briefly below, followed by a detailed description of the various steps in the programme.
12. In terms of community and beneficiary participation the programme is carried out by the panchayat, the Ward Water Committee and community working together with the SEUs. The strategy emphasizes community leadership and responsibility for implementation. The various groups involved in the programme are described below:
  - a) The strategy of the programme is based on a written contract in which the panchayat and the groups noted below agree to manage and implement the programme following certain procedures. Together with the Socio - Economic Units, panchayat also contributes, on a voluntary basis, for this programme. the amounts range from as little as Rs.500 to as much as 5 lakh rupees. In most cases the panchayat contribution is used to provide latrines to the very poorest people at the end of the standard construction period. However, the contribution must be deposited in a bank account, jointly operated by the panchayat and Socio - Economic Unit before the programme can begin.
  - b) An executive committee looks after the day-to-day affairs of the programmes (including constructions and education activities). The Executive Committee members are: the Panchayat President, Executive Officer, an SEU Official, one lady member (elected by all the WWC members or the women WWC members). The Ward Members form the ward where programme implementation is ongoing, is a special invitee to the Executive Committee. The Executive Officer is responsible for keeping the accounts for this programme. These accounts are checked periodically by the accounts officer from the



Socio-Economic Units and are subject to an occasional audit check by an external auditor.

- c) The Ward Water Committee is in charge of general implementation of the programme in each ward. The Ward Water Committee is a voluntary group of seven people which includes the elected ward member, at least 2 women, and representatives from groups that are active in the ward. This may include, for example, a teacher, anganwadi worker, health worker, or leader of a women's group or youth group. It is important to note that this composition ensures that all active groups, all points of view and all, local political interests/parties are represented. The convener of the Ward Water Committee is usually not the elected ward member. The latrine-with education programme is not the only activity of the Ward Water Committee. In addition to the sanitation programme, the Ward Water Committee is also active in other water-related programmes for piped water systems, chlorination of wells, environmental sanitation, and so on.
  - d) For every 1 or 2 panchayats there is a field organizer who works for the Socio-Economic Units and oversees community work related to health education, piped water schemes, environmental sanitation as well as this latrine-with education programme. The Field Organizer, covering a population of 25,000 or 50,000 is the primary link between the Socio-Economic Unit and the Ward Water Committees/Panchayat.
13. There is an important education/communication component which is meant to be continuous and community-based. Education and communication activities occur at set intervals:
- There is a 3 to 6 month general mobilization, with a range of activities such as group meetings, exhibitions, camps, street drama. This is meant to build up demand, inform people about the health aspects of latrines in general.
  - Specific training for masons in construction and about imparting health/sanitation messages to the families.
  - Three classes for beneficiaries each targetted on a specific topic (health, technical aspects, maintenance and use)
  - Training and planning activities for the Ward Water Committees and relevant panchayat officials involved in the programme.
  - Follow-up monitoring by the Ward Water Committees and other local groups.
14. With respect to construction, the target for this programme was 50% of the below poverty-line households. Now it has been decided to cover

100% of the below poverty line population. By 30 th September 1993, 18,000 latrines had been constructed in 32 panchayats. On basic latrine model is made, with variations taking in accounts local conditions and availability of materials. This is the double-pit, pour flush latrine, with a complete superstructure except in one panchayat. AS of September 1993, the cost of each Unit ranges for Rs. 1680 to Rs. 2300 (except in water-logged areas where costs are higher). The price is different in each panchayat depending on the cost of local materials an labour. Costs are carefully set through the construction of demonstration latrines at the beginning of work in each panchayat. maximum use is made of locally available materials and local masons for each programme. It is important to keep down the costs because poor families can not afford large contributions (calculated at 20% of construction costs plus digging pits). It is also important to reduce costs in order to stretch our existing resources as far as possible.

15. In addition to the construction costs, there are overhead charges which include costs of the initial motivation campaigns, staff salaries and transportation. The total overhead charges are estimated to range from Rs. 100 to Rs. 150 per latrine constructed. These costs are relatively lower than in many other programmes because of the high level of community involvement and the special effort to find the lowest cost for construction using local materials. The check list used during the construction time is given in appendix -1. Similarly every three months the use and maintenance of the latrine is also followed up by the representative of the ward water committee and the format used is given in appendix - 2.

## THE STRATEGY IN STEPS:

16. The following paragraphs describe our current programme for 75% subsidy in detail. The management and administrative aspects are shown, step-by-step. The selection of panchayats depends on two things. First, the panchayats must be those in which the water schemes supported by the bilateral governments are also being implemented. The responsibilities of the panchayat and the SEU has been clearly stated in the contract. Second, the panchayats should fulfill certain criteria which are indicate in appendix- 3. The programme as approved and supported by donors, is able to reach at most 50% of the population below the poverty line. Therefore a careful selection must be made to ensure that beneficiaries are really among the needy and, sometimes, when those apply exceed the target set. The beneficiaries are selected by the Ward Water Committees,

based on a set of criteria and this has to be agreed upon by the Ward Water Committee members. The criteria adopted are as follows:

- Families below the poverty line currently defined as a monthly income of below Rs.500/-
  - Beneficiary should express keenness to own a latrine and participate in all the health education activities
  - There should be adequate water to maintain the sanitary latrine
  - There should be sufficient place to construct a two pit latrine without causing any problems to sources of drinking water and other households.
  - There should be a minimum distance of 10 meter between the latrine pits and existing drinking water sources;
  - Households to be given priority are: (a) headed by disabled or handicapped; (b) headed by widows (c) scheduled castes or tribes not already served by other sanitation programmes.
  - Land to construct the latrine and house should be owned by the beneficiary
  - The total beneficiary contribution is 25%. This is usually equivalent to the digging of the pits plus 20% financial contribution. Beneficiary should dig the pits. The beneficiaries and the WWC are responsible for local transport of material.
  - If other criteria are needed for beneficiary selection, the following should apply. -huts and colonies; - owning less than 5 cents of land;- number of female children; - number of economically active people in the household.
17. After the Ward Water Committee has done the selection, a check is made by the Field Organizer who works for the Socio-Economic Units. The list of beneficiaries is also displayed in the panchayat building, in health clinics and other public places so that anyone can raise questions.

## **STEPS IN IMPLEMENTATION FOR EACH PANCHAYAT**

### *1. Identification and selection of Panchayat:*

See appendix 3. Activities will normally be undertaken in two wards at a time to allow for more efficient construction work. The education programme may work in more wards at the beginning.

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See Chart on Steps involved in implementation programme on next page.



# STEPS AND TIME FRAME FOR IMPLEMENTATION - FOR EACH PANCHAYAT

Month >	1	2	3	4	5	6	7	8	9	10	11	12	13
Action													
1. Identify/select panchayat	_____												
2. data to be collected	_____												
3. panchayat meeting	_____	_____											
4. construct demo latrine		_____											
5. role of panchayat	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
6. panch. plan & contribution	_____												
7. WWC training	_____	_____											
8. mobilisation & health education	_____	_____	_____	_____	_____	_____	_____						
9. beneficiary selection/ contribution				_____									
10. beneficiary education			_____	_____	_____	_____	_____	_____					
11. identify/train masons							_____	_____	_____	_____	_____		
12. pit marking pit digging							_____	_____	_____	_____	_____		
13. construction, purchase								_____	_____	_____	_____	_____	
14. use and maintenance						_____	_____	_____	_____	_____	_____	_____	_____
15. technical verification							_____	_____	_____	_____	_____	_____	_____
16. follow-up & monitoring												_____	
17. documentation	----	----	----	----	----	----	----	----	----	----	----	----	----

## 2. Survey of Panchayat:

Collect data on all panchayats. See appendix 3 for the data being collected.

## 3. Panchayat Meeting:

To brief the panchayat about details for the programme, cost, technology, beneficiary participation, role of each committee - health education and how to submit the panchayat proposal and contribution etc.

#### *4. Construct demonstration latrines:*

This should be constructed in each panchayat to determine the exact costing for that panchayat. Check carefully labour costs during this construction. The demonstration latrines should be built for the ICDS, health clinic. for example. In some cases the SEU will decide to do two constructions: one for the demonstration latrines and another to arrive at the costing.

In many cases the constructions is also a time when local masons are trained. They will be active in the rest of the programme.

The costing of the latrine in this way determines how much subsidy will be given for each latrine in that panchayat. It also determines how much the beneficiary will have to contribute (20% of the price of construction). The SEU therefore try to cut down the cost at this point for each panchayat, using locally available materials.

#### *5. Orientation of Panchayat and executive committee:*

An executive committee comprising of Panchayat President, Executive Officer, KWA Assistant Engineer and SEU Official, one lady member (not necessarily an elected representative) from PWC will look after the day-to-day affairs.

#### *6. Project Proposal:*

Resolution to be passed by the panchayat and submitted to SEU. The panchayat and Socio-Economic unit opens a joint bank account (joint signature by Executive Officer and Programme Officer). The Panchayat contribution is first deposited before the Socio-Economic Unit deposit (amounting to 75% of the construction cost plus 1% overhead). Agreement with panchayat must be completed and signed.

#### *7. WWC training*

Ward Water Committee is in charge of general implementation of the programme and subcommittee will be responsible for all the health education activities. Training and preparation for health education activities for 12 months

#### *8. Mobilisation Campaigns:*

Will be carried out by WWC together with existing local agencies such as ICDS and PHC for at least 3 months.

#### *9. Beneficiary Selection:*

The forms provided by the WWC are scrutinized and verified to ascertain eligibility. The list will be displayed in different parts of wards for public comments. The list must then be scrutinized and approved by Panchayat Water Committee.

### *10. Beneficiary Contribution and meetings:*

20% of the cost for the latrine has to be borne by the beneficiary. Other responsibilities of beneficiaries are: preparing two pits of appropriate size, transporting materials from the main road or store house to the site, assisting the helper etc. A separate register has to be maintained in the panchayat beneficiary.

During this time the education meetings are held for beneficiaries. Attendance is required.

WWC will be responsible for motivating beneficiaries to, pay the contribution. This can be deposited in instalments, or in lump sum at the panchayat.

### *11. Identification and training of Masons:*

Ward Water Committee identifies local masons. Experienced masons, and SEU staff give the training. In addition, masons are given training in talking about the technology and health aspects of sanitation to the households. Special training and planning for working with women masons will be needed where possible.

### *12. Pit Marking and Pit Digging:*

Marking on ground is done by a technical person/health inspector and trained WWC members. Beneficiary digs the pit according to the dimensions explained by the technical person or Ward Water Committee member.

### *13. Construction and purchase:*

For convenience, construction could begin in two wards. Quality of construction has to be periodically inspected by the Sanitation Supervisor. SEU staff should in any case make spot checks during construction period. The report of the periodic and spot inspections should be given to the Executive Committee. Intense health education activity (4-5 months) to begin at this stage. Also emphasize the role of mason/draftsman as agents of health education in individual beneficiary houses.

Executive Committee decides on sources of procurement. Printed voucher are used for all purchases. Voucher is approved by sanitation supervisor and countersigned by ward member. Separate cash book for all remittances and withdrawals are maintained in the panchayat. It is the responsibility of the Ward water Committee to see that transportation of materials is done by beneficiaries as a group.

Sanitation Supervisor has to submit weekly report of progress and monthly accounts. Field Organizer/SEU official to make fortnightly visits. Each sanitation unit must have a serial number. SEU to maintain list of these.



Specific procedures and forms or vouchers for purchase, account, and supervision are used.

#### *14. Use and Maintenance:*

Guidelines on use and upkeep of latrines are given to each family once again in small group meetings. These are conducted by Ward Water Committee. Also at this stage, a booklet/leaflet or instruction in use and often a brush to clean are provided. Emphasis is given to the following:

- Children and men should use latrines
- Washing hands with soap/ash after defecation
- maintaining water seal
- preventing blockage
- keeping surroundings and latrine clean

#### *15. Technical Verification of Units:*

SEU personnel and representative from Panchayat or health department certifies fitness.

#### *16. Follow-up:*

Ward Water Committee conducts periodic follow-up of the latrine. Half-yearly monitoring can be carried out by outside agency and report to PWC and SEU.

#### *17. Documentation:*

All stages of activity are documented.

## **SUMMARY & CONCLUSION:**

18. As explained above with the help and support of the community and the Panchayat, positive effect have been created through out the project area. More and more Panchayats are showing interest and commitment to contribute financially for starting the programme in their panchayats. As of September 1993 approximately Rs 20/- lakhs have been contributed by various panchayat for the programme. As of end September 1993, 18000 sanitary latrines have been completed in 32 panchayats with participation and education. The usage pattern is more than 90% and the beneficiaries are keeping the latrine absolutely clean. The proportion of children using the latrines is also very high when compared to other Kerala programmes. As we all know that the coverage of sanitary latrine is about ten percent in the country, in Kerala it is approximately thirty per cent. Sanitation programme which started in India since 1943, has yet to make much progress. This is more true in the case of increasing the coverage and

proper use and maintenance of the available facilities. Even in a highly literate state like Kerala the environmental conditions are not as encouraging as it should be. Many sanitation programmes in Kerala and other states were not able to contribute meaningfully due to the absence of effective community participation and education programmes. Hence, there is an urgent need to review and study the experience of ongoing sanitation programmes implemented by various groups for developing an effective and sustainable low cost sanitation programme for improving the quality of life.

9. Most of the sanitation programme lacks a strategy and management style to implement the community based low-cost sanitation programme. It is a great pleasure to announce here that the Socio-Economic Units, in Kerala was able to develop a strategy for implementing the low-cost sanitation programme and this is prepared based on the experience gathered from the community since 1987/1988. This programme has attracted interest from several donors and implementing agencies. We feel that we have to learn more technical aspects on low cost latrines in water-logged conditions. I take this opportunity to invite critical comments and suggestions from the participants to improve the low-cost sanitation strategy used by the Socio-Economic Units, Kerala.

## Appendix- 1

### QUALITY CONTROL DURING CONSTRUCTION OF LATRINES

#### Checklist for Supervisors

##### 1. Location of the latrine

distance from the well less than 5 meters

Yes/No

5 to 10 meters Yes/No

10 Meters + Yes/No

2. distance between the pits: 90 cms (equal to effective depth of the pit)

Yes/No

##### 3. Pit lining:

Pit lining above the drain pipe

Yes/No

Pit lining below the drain pipe

Yes/No

Tendency / sign of pit collapse

Yes/No

Earth filling outside pit wall filled / not filled

Pit top's level equal/not equal

pit slab air tight

Yes/No

##### 4. Drain pipe

Drain pipe projection from the wall of pit . . . .cms

Drain pipe slope

adequate/not adequate

##### 5. Junction box:

'Y' channel base 'U' shape

Yes/No

Blocking lid available/not available

Proper slope in the channel from

P' trap to the pit

Yes/No

##### 6. Pan an trap:

distance from the back wall 18 cms

Yes/No

Water seal in the P trap

Yes/No

##### 7. Foot rest:

at 40 angle

Yes/No

##### 8. Room:

Floor condition Good/bad

adequate slope to drain water to the pan

Yes/No

Crack in the floor

Yes/No

##### 9. Ventilation:

Yes/No



## Appendix - 2

### MONITORING FORMAT FOR USE AND MAINTENANCE OF LATRINES

1. Panchayat	.....			code
2. Ward No.	.....	3. House No.	.....	
4. Latrine No.	.....	5. Date of latrine built	.....	
6. Number of persons using	.....			....
7. If it is more than 2 years in use ask did you change the pit			Yes/ No.	....
If yes indicate the date	.....			
<u>8. Condition of Pan &amp; trap:</u>				
a. Yellow colour	Yes	No		....
b. Scratches or breakage on the pan	Yes	No		....
c. Colour fading	Yes	No		....
d. Availability of brush	Yes	No		....
e. Environmental condition good (without faeces, sand, mud, etc.)	Yes	No		....
f. Foul Smell	Yes	No		....
<u>9. Behavioural practices:</u>				
a. Water kept inside	Yes	No		....
b. Water kept outside	Yes	No		....
c. Soap kept nearby	Yes	No		....
d. Use by children below 3 years	Yes	No		....
e. Above 3 years ask the children do you use latrine	Yes	No		....
10. Check whether the person is aware of the purpose of water seal	Yes	No		....
11. Check whether person is aware of the purpose of junction box	Yes	No		....

## Selection of the Panchayat

The following guidelines are followed in choosing the Panchayats for the sanitation scheme.

1. Interest within the panchayat should be high for this programme. Ways of assessing this might include:  
Is the Ward Water Committee active and strong in the panchayat? Is the panchayat agreeing with these guidelines?  
Does the panchayat wish to offer a contribution which would be used to expand coverage in that Panchayat?  
Are there groups (youth clubs, ICDS, Women's clubs, schools etc) that would be interested in collaborating in this programme in the panchayat?
2. Availability of water for the latrines.
3. Preferably less than 50 percent households should have sanitary latrines.
4. Preferably with historical occurrence of water-related diseases in large number (for example, coastal areas with low sanitation coverage)
5. Panchayats with low income.

### Data to be collected

1. Name of the Panchayat
2. Population of the Panchayat (by ward)
3. Number of Wards
4. Grade of the Panchayat
5. Number of Households
6. If possible, number (and % ) of households below poverty line in each ward
7. Number of house with latrines in each ward at beginning of the programme:
8. Revenue of the panchayat for the current financial year and last financial year
9. How many subsidized latrines have been constructed in the panchayat to date (by Ward)?  
Number of Units \_\_\_\_\_
10. Are there any on-going sanitation programmes? Where, what kind and how much is being constructed?
11. Particulars of needy areas and colonies by ward

12. Particulars of active institutions in the panchayat  
a ICDS Centres; b Schools; c Colleges;es; d Health Centres; e Others
13. If available, place collect statistics about water-borne diseases in the panchayat for the past two years (for example, from PHC)
14. Water Availability (Optional)

In Asia family size has fallen substantially in Sri Lanka and Thailand since the mid-1970s, based on comparisons of DHS and WFS data. In Thailand the TFR has fallen from 4.6 children per woman in the 1975 WFS to 2.3 in the 1987 DHS, a decline of 50%. In Sri Lanka fertility has fallen almost 30%, from 3.8 in the 1975 WFS to 2.7 in the 1987 DHS. Also, in Indonesia fertility has fallen from 5.6 children per woman, estimated from the 1971 census, to 3.0 in the 1991 DHS, a decline of 46% (19).

By comparison, fertility is much lower in the developed world, estimated at about two children per woman (351). The TFR is 1.7 children per woman in Japan, 1.8 in the United Kingdom, and 1.9 in the US.



# 13 PEOPLE'S INVOLVEMENT IN DEVELOPMENTAL PROGRAMMES FOR WOMEN AND CHILDREN

*Rajammal P. Devadas\**

Health and development of women and children form an integral component of overall socio-economic development of any nation. The developmental programmes in India aim at bringing a radical transformation in life style, beliefs and general outlook of people. These programmes would not exist by themselves and hence warrant the participation of the community or the beneficiaries for the complete success.

People's involvement should be the hall mark of any development programme. Various functionaries, voluntary bodies, educational institutions and members of the community can make useful contribution in bringing about people's participation at the grassroot levels. Eliciting people's involvement and participation is one of the most arduous tasks in many ways.

Some research studies have been carried out by Avinashilingam Deemed University to elicit mothers' involvement in the community towards health and development of women and children. These studies focus on effective, educational interventions and their impact on positive attitudes and behaviour of the local community and beneficiary families towards supporting and participating in the health development schemes.

Devadas and premakumari (1988) conducted a study with the multipurpose Health workers (MPHW) in Nallur Block. After receiving training the MPHWS were able to change the participatory behaviour of rural communities. As a result of the education programme they had conducted, 85 per cent of the villagers immunized their children against infectious diseases; 130 families in the Block constructed latrines in their houses; the villagers raised a platform around the drinking water tap in three villages; and cleaned the water stagnated areas. Mother in 40 families used hay box for cooking rice and more than 200 mothers had raised kitchen gardens in their houses. Educational intervention undoubtedly improves people's involvement for their own welfare and development.

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Table I depicts the nutritional profile of children born to the mothers who had attended nutrition intervention cum education in another study (Devadas et al 1984.)

**TABLE I**

**NUTRITIONAL PROFILE OF CHILDREN (3.5 YEARS OF AGE)  
BORN TO THE MOTHERS WHO ATTENDED NUTRITION  
EDUCATION SESSIONS.**

Measurements	Children born to the mothers who attended nutrition education ses- sions  N = 25	Children born to the mother who were not exposed to nutrition edu- cation sessions  N = 25
Height (CMS)	93.27	91.27
Weight (Kg)	12.40	11.79
Arm Circumference (CM)	13.61	12.80
Chest Circumference (CM)	49.04	48.08

The nutritional profiles of children born to mothers who were exposed to nutrition education were better than those of the children whose mothers were not exposed to any nutrition education sessions, although they come from similar socio economic background. The mothers who were exposed to the intervention cum education programme were motivated to give proper supplementary foods without adding to the cost of their family food budget, by using locally available low cost foods. They also followed the immunization schedule. All these enabled the mothers to provide their next child with better nutritional care.

Jaya and Jaya (1992) studied 300 Women in the age range of 20-35 years and found that the health status and education of women was positively and significantly correlated. Education of women, is thus vitally important. In another study 150 mothers from five Anganwadies in Coimbatore were selected for health education over a period of two months. Along with substantial increase in mother' knowledge related to health and nutrition of children and women, changes in their behaviour and practices were observed. Fifty five per cent of the mothers had adopted measures to improve sanitary conditions; 70 per cent availed health check ups and 75 per cent of pregnant and lactating mothers availed the ICDS services (Shanthi and Jayapoorani, 1992).

Education classes for 150 mother of two Anganwadies had yielded positive outcomes in terms of mothers' involvement as shown in the following Table II.

**TABLE II**  
**MOTHERS CONTRIBUTION TO THE ANGANWADI**

Mother's contribution	Impact of education on mothers contribution N = 50	
	Before	After
Sending Children regularly	10	38
Helping in cooking	4	38
Offering vegetables	4	28
Contributing low cost play equipment	6	20
Providing mats	6	17

Prior to education only six mothers had contributed low cost play equipment and mats and four mothers had offered vegetables and help for cooking in the Anganwadi. After the training, the number helping and increased substantially though there is scope for improvement (Glory and Vasantha, 1992).

In a vast and populous country India development of women and children can be achieved only through the combined efforts of the women themselves the government and voluntary organisations. Health and development of women and children need to be envisaged as a co-operative venture between the state and voluntary organisations, the latter complementing and supplementing the efforts of the former.

### **Eliciting People's involvement**

Voluntary agencies have been pioneers in initiating programmes for development of women and children. People's involvement is a vital necessity if any programme has to succeed. The following are the approaches in that direction.

#### **1. Involvement of beneficiaries**

Voluntary organisations are nearer to the people and are in a position to elicit involvement of the beneficiaries in the implementation of programmes aiming at health and development of women and children.



## **2. Literacy Mission**

Poverty and illiteracy are problems of great magnitude; in addition they create other problems, are responsible for huge wastage of human resources in the country. In India, a large number of children die before they reach the age of five years, and many mothers do not receive proper care during pregnancy and child birth. Though a number of programme have been initiated to prevent these problems, it has now been realised that unless a change is brought in the attitude of the great mass of our people through proper education on the issues of mother and child care, no spoon feeding programme can really result in a permanent improvement in the health status of women and children. Viewed in this perspective, it becomes imperative that the National literacy Mission programme includes, besides other aspects, elements of mother and child care for providing necessary support to the related programmes. It becomes important that the functionaries of literacy programmes are oriented to the basic philosophy and approach to women and child development so as to enable them to integrate effectively these components in their educational programmes.

## **Orientation to youth**

The youth of India, representing a third of her population constitute a vital and vibrant human resource. The government and voluntary organisations have involved the youth in a number of welfare and development programmes for women and children. It has been realised that the youth are responsive to new ideas and willing to shoulder responsibilities. If youth power is harnessed properly, it can prove to be a potential work force for different welfare development programmes of the country and can also be of great help in the prevention and eradication of many social evils and problems which are rooted in the society. It is imperative that youth leaders are motivated and oriented to participate in the welfare/development programmes and mobilise the community, in turn.

## **Training Adolescents**

There is an increasing trend today in teen age pregnancies where in million of girls of 14-18 years are compelled to engage in child bearing and child rearing even before they have had a chance to complete their own physical growth and development and attain adulthood. This is 'Child Labour' at its worst for it carries for greater risks than some of the other forms of child Labour.

Delineating the factors responsible for the poor status of maternal and child health in the country, Gopalan 1993 has mentioned that "It is our total"

neglect of the care of the adolescent that has been responsible for the poor performance in the fields of maternal and child health and family planning. Adolescent girls need to be prepared and equipped for safe motherhood and productive citizenship well before they are 'trapped' into marriage and maternity. In order to achieve an increase in the average age at marriage and delay the onset of the first pregnancy till the 21st year Gopalan has suggested that incentives like 'delayed marriage bonus' and 'delayed-maternity bonus' be offered to the poor.

## **Mahila Mandals and Yuvak Mandals:**

There are approximately 55,000 Mahila Mandals functioning in rural areas of the country. Their activities include child care and nutrition services through Balwadis and Creches, health sanitation, family welfare, socio-religious and cultural activities, individual or group projects in agriculture and allied fields such as kitchen gardens, orchards, poultry, dairy units, fish ponds and other economic activities of training and production in crafts using local materials and small savings. Similarly, around 10,000 Yuvak Mandals are reported to be working in the rural areas as partners in development. Their activities included individual and group projects in agricultural and allied fields, recreational and cultural activities, community services including assistance in creating community assets, health, sanitation and population education.

In recent years, several steps have been taken to promote and strengthen Mahila Mandals and Yuvak Mandals in order to have active organisations in every village/Gram panchayat.

### **These measures include:**

- a. Helping the Mahila Mandals/Yuvak Mandals adopt a simple constitution in local language
- b. Assisting them in getting themselves registered by simplifying the procedures of registration and reducing the rates of registration fees
- c. Giving them a nucleus administrative grant for recurring and non-recurring purposes to enable them to strengthen their organisation
- d. Arranging orientation of their office bearers in organizational aspects
- e. Helping them to form block and district level Federations and
- f. Helping them develop a definite programme with or without grants-in-aid.

The other local voluntary groups which have emerged in the rural scene is a large number of village cooperative societies providing consumers service and facilities of credit, storage, processing and marketing.

However, not all voluntary groups of the kind described above function efficiently. Many continue to depend on extension machinery of the block for their very creation and subsequent growth and development. One of the methods of making such organisations more effective would be to have their representation on the panchayat Raj bodies and the representative of the panchayat Raj bodies on their managing bodies and Vice - Versa. With adequate assistance and guidance these organisations can ultimately become broad-based and undertake programmes for development of the entire community instead of limiting their interests to development of a particular section of the village population.

The insights gained through researches and experiences must be utilized fully and disseminated to individuals/organizations/institutions for appropriate actions. A concerted effort is required to incorporate the crucial indicators identified for successful involvement of the community into the training curricula of personnel of various levels. The community committees/representatives should be identified carefully and trained to assume responsibilities. There is a tremendous scope for enhancing the extent of community participation, provided skills/initiative of the workers in eliciting community participation, existence of effective committees/women's groups, frequency of their meetings and involvement of local voluntary organizations are strengthened and tailored to the needs of people.

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### **What is health?**

A healthy individual is a man who is well balanced bodily and mentally, and well adjusted to his physical and social environment. He is in full control of his physical and mental faculties, can adapt to environmental changes, so long as they do not exceed normal limits; and contributes to the welfare of society according to his ability. Health is, therefore, not simply the absence of disease: it is something positive, a joyful attitude toward life, and a cheerful acceptance of the responsibilities that life puts upon the individual.

From: Sigerist, H. E. Medicine and human welfare, New Heaven, Yale University Press, 1941, p. 100.

We all have a responsibility to ensure that those infected with HIV are not discriminated against.

# 14 TEACHER - A CHANGE AGENT THE IMPACT OF HEALTH EDUCATION TRAINING:

*P.M. Prema*

## 1. INTRODUCTION

By organising an effective school health programme for the younger generation, the future of community health can be promoted, as “the destiny of the nation is shaped in its classrooms”. In the present school curriculum, health education does not occupy the status of other curricular subjects like sciences, mathematics, languages etc., Hence under the prevailing conditions, if the teachers are trained to incorporate health in the existing curriculum, to correlate health with other subjects, to strengthen the existing health contents, and to develop co-curricular activities in health, children would immensely benefited and learn to behave positively in health, related matters. Incidentally it is to be remembered that training teachers in health education is one of the major activities under school health programme.

## 2. Health Education Training Programme.

**2.1. Health Education Teacher Training Unit:** Keeping the above points in view, the Health Education Teacher Training unit (Institute of Public Health, Poonamallee) is conducting training programmes for high school and higher secondary teachers and their headmasters.

**2.2. Health Education Training For Teachers:** Training is conducted based on a prepared syllabus for the purpose. Various aspects of health, Viz. anatomy and physiology of various systems of the human body, communicable and non-communicable diseases, food and nutrition, environmental sanitation, personal hygiene, population education, sex education, safety and first aid community health, school health programme and so on are dealt in the class room as well as in the field using appropriate educational methods. Educational visits to various institutions of public health importance are also arranged. Besides, the trainees are guided in performing many practical activities. This is in keeping with the chinese saying,

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If I hear I forget

If I see I remember, &

If I do I know

**2.3. Health Education Training for Headmasters:** In order to orient the headmasters about the teachers training programme and to suggest as well invite ways and means to develop team-work in health education activities headmasters are given a short-period training programme. One of the activities is to provide them with a direct experience of the impact of health education training on school activities. For this purpose a school visit is arranged.

### **3. Impact of health Education Training on a higher Secondary School Teacher:**

**3.1. Observation visit:** During the year 1984, 7th batch of headmasters undergoing health education training were taken to St.Pauls' H.S.School Vepery for the observation visit. The reason for choosing the school was its uniqueness in having three teachers and their headmaster trained in health education. It was also to show them that the team-work by the headmaster and the teachers paid high dividend in improving the health-status of the school children.

**3.2. Health Education Training Teacher- A change Agent:** One of the health education trained teachers a participant in the 63 rd batch explained to the headmasters gathered about the individual health counselling that he was giving (an off-shoot of his training in health education)- He narrated a successful case-example. It related to a drunkenfster of one of his students. Though he had a number of years of teaching experience at his credit, he had never observed any sudden change in his students. He used to attribute scholastic backwardness to sluggishness and dis-interest on the part of students. But the knowledge he gained in T.T.K. Hospital (One of the institutional visits arranged for the teachers) through the lectures on alcoholism and the children of alcoholics, was able to open-up a new vista and that enabled him to observe a particular student whose interest in studies found to be decliming. Suddenly his academic performance was going down. He was not attentive and concentrating in the class. Inside the class-room sometimes he appeared to be totally lost. It seemed as though there was no happiness left in him. He appeared to be anxious and depressive.

He was not carefree as other children. When the teacher conducted an indepth and sympathetic enquiry, he was able to find-out the level to which the boy was driven because of his father. His father had drowned himself in alcohol.



Previously his father used to drink occasionally. The student was not able to concentrate on studies because all the time he was pre-occupied and worried about his family. "Today, would my father be sober or in a drunken-stage? would my mother and I be getting beatings unnecessarily. Poor mother ! how would she be able manage the house-hold expenses when father spent all his salary in drinks! Sir, tell me, how can I concentrate on studies, when there is no peace of mind?" Thus he poured out his state of affairs to the sympathetic and understanding teacher. The teacher was able to understand his student's mental agony.

Subsequently the teacher met boy's father and counselled him on his addictive behaviour and his son's academic performance was affected because of his addiction. The knowledge that he gained in his health education training programme enabled him to guide the boy's father to take-up necessary treatment and successfully brought him out of drinking habit. It took quite a few months for him to achieve this goal. And it was such a rewarding experience for the teacher that his joy found no bounds. That student had no words to express his happiness and he became a cheerful, and enthusiastic boy once again, and he was plying, laughing and participating in the school activities as before.

#### 4. CONCLUSION

Teacher are there not only to teach the 3 Rs. but their job is to mould the whole personality of the child. Not only this, if they are guided properly and counselled in the right way to realise their role, they can bring about many a change in the larger community of which their students form part of. The above narrated incident is only a drop in the ocean of changes that they can bring about in the health and development of the society.

Prevalence rates in excess of 0.5% for BITOTS Sports and 0.01% of active corneal lesions are used as the criterion for considering the existence of **VITAMIN A Deficiency** as a Major **PUBLIC HEALTH Problem**.

# 15 AIDS PREVENTION THROUGH EDUCATION AND HEALTH PROMOTION

*Dr. P. Krishnamurthy*

1. AIDS is more than just the clinical complication of a Virus infection. HIV positivity and AIDS reflects wide ranging consequences on individuals, families, peer groups and community. It is always better to prevent disease than to cure it, but in the case of AIDS when it cannot be cured it is obvious that Primary prevention is the only means for not getting infected.

2.1. Many educational programmes related to Health care failed, because they are imposed from above. They are often found to be unacceptable and or inappropriate and without a thorough researching of the determinants of the behavioural pattern, which it is hoped to change. In particular the components of the social environments may need careful isolation before introducing an educational programmes.

2.2. Health Education to control and prevent AIDS is not an easy task. It primarily is to orient the cognitive frame and influence people to change their behaviour. The behaviour change warranted in AIDS education is sexual. The culture bound society of Tamil Nadu considers sex too personal, and not to be discussed even in private. The Taboo and stigma linked with sex even among the married couples and educated adults makes health education in AIDS more challenging. Also it demands thorough understanding of AIDS prevalence and spread.

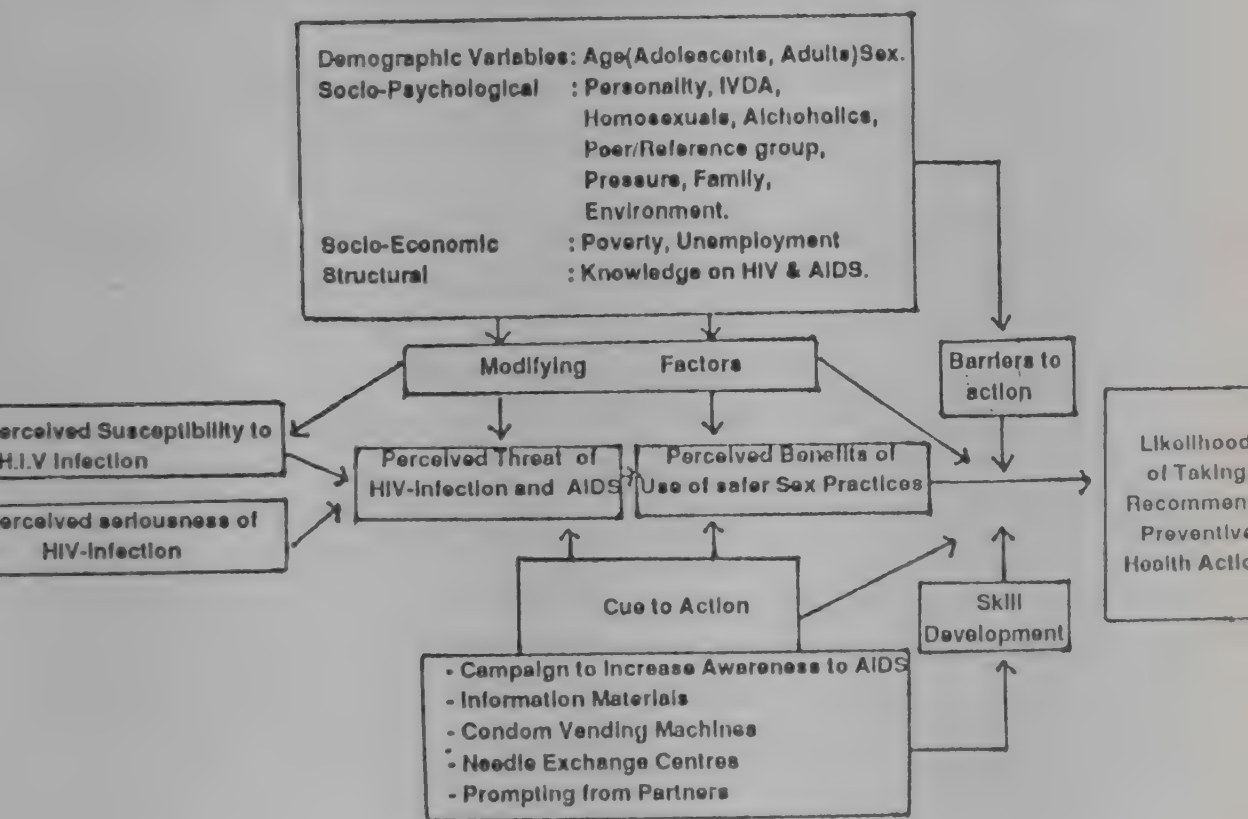
2.3. AIDS education is also dependent upon clear understanding of the social and behavioural characteristics of the people. They include demographic variables, socio-psychological characteristics, socio-economic factors and level of knowledge and attitudes on HIV and AIDS. The level of perception of an individual to susceptibility to HIV infection and how seriously it is perceived is a matter of concern. Weighing and outweighing the pleasures of sex and risk of HIV infection is influenced by his level of knowledge on AIDS and the seriousness of risk due to unprotected sex. Individuals can adopt safer alternative action for preventing a possible health hazard is explained in the model given below.

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## Education for the Prevention of AIDS

### Health Belief Model as Predictor of Preventive Health Behaviour



3.1. A standard communication model for AIDS education is similar to other educational plans and requires a knowledge of the local epidemiology of AIDS, a thorough understanding of the culture and behaviour of target populations including an awareness of prevalent beliefs, myths and risk practices and familiarity with the strengths and weaknesses of locally available models of communication.

3.2. A major conclusion is that there is no single approach that is right for all cultures and communities.

3.3. AIDS education activities need to be supported by the other essential services such as those for HIV testing, availability of condoms, counselling and staff training, management of AIDS patients, safer blood banking system, and the whole programme has to be implemented according to a carefully co-ordinated time table bearing in mind available human and material resources.

3.4. Appropriate messages and materials are to be designed and suitable channels of communication selected. Target audiences should be involved in the design and testing of messages and materials.



3.5. AIDS education provision can be integrated into the existing health services and network channels of communication readily available. The expertises of the staff and of volunteers from such network may be made use of.

3.6. Monitoring and evaluation of the planned educational interventions are necessary, so as to influence further programme modification and development.

4.1. Developing an operational strategy for AIDS prevention through education is facilitated by analysing and answering the following questions.

- Who are the target audiences
- Who will be principal educator communicators.
- In what settings/environment they will be operating
- What are the messages and materials
- How they will approach and what strategy will they adopt.

4.2.1. Every individual in the community faces a potential risk of infection with HIV. High risk audiences are identified for intensive education and counselling. While planning for Health Education an appropriate balance is to be maintained between generally directed public education and campaigns aimed at particular target audiences like sex workers, travellers, STD patients, drivers, IVDUS etc.,

The audience for AIDS education include:

- A. Professional groups
- B. High-risk groups
- C. HIV carriers or AIDS patients
- D. General population.

4.2.2. **PROFESSIONAL GROUPS:** (1) Health professionals and para health professionals form an important group for the reason that they have direct contact with HIV carriers, AIDS patients and high risk groups. They are also special, because they could accidentally introduce the infection to an innocent client through their lenient attitude and careless approach in their therapeutic practices. The health professionals include

- (i) doctors of modern medicine; general practitioners, specialists; working with government, NGOs and in Corporate and private sectors.
- (ii) Practitioners of Indian System of Medicine.
- (iii) Less or not qualified practitioners of medicines (Dais, Quacks etc.)
- (iv) Blood Bank operators; Government and Private.

- (v) Special Units in the hospitals; like Emergency Care Unit, transplant surgery units etc.,

(2) AIDS prevention demands high level of intersectoral coordination. Professionals of other sectors also form sizable audience for ededucational planning. They include

- (i) Teaching Professional working in colleges, and schools
- (ii) Police personnel
- (iii) Other professional, working in sectors like agriculture, animal hubandary, tourism, industries, Public Works including camps, site construction etc.,

**4.2.3. HIGH RISK GROUP:** AIDS education should be realistic, factual and it should reflect the true picture of the hazard, the high risk group is facing in their specific behaviour; the education plan includes special campaigns, individual and group counselling, etc. for this group of high risk people. They are:

- (i) Sex workers
- (ii) STD Clinic patients
- (iii) Clients of sex workers
- (iv) Promiscuous persons
- (v) Intervenous drug users
- (vi) receipents of blood and blood products
- (vii) professional blood donors.
- (viii) Spouses of HIV infected persons.

**4.2.4. HIV CARRIERS AND AIDS PATIENTS:** Apathy and depression among these patients is to be approached with sympathy on humanitarian grounds. For these patients, uncertainty emerges with regard to quality and length of life, effect of treatment, response of the society and family and in general the hopes and expectations of the life is shattered. Family members, peers and professionals are to be educated to discuss openly and frankly, but care should always be taken to encourage hope and a positive outlook.

**4.2.5. GENERAL POPULATION:** Social mobilization is a key factor in AIDS education. Modification in the life styles of people is most expected in the planned intervention to prevent and control AIDS. Such positive expectations are possible through general education of the community. Such trans-sectoral appraoch will enable mobilisation of human resources through senitisation of leaders, social workers, women, young people etc., It should address the following groups of general population.

- (i) Adult members constituted by religious leaders, political leaders, youth leaders, social workers, industrial managers and workers, working men and women, workers in unorganised sector, parents, house wives, etc.,
- (ii) Youths, adolescents and adults; studying, working, unemployed, unmarried or recently married etc.,
- (iii) General vulnerable groups like migrant people, single men and women living alone, hostelers, living in crowded settlements, tourists, people living in slums, etc.,

**4.3.** Education of the audience is to be pioneered by set of select communicators to begin with. They include

- (i) Professionals, like doctors working in government sectors, Private Practitioners, Medical Officers of other Systems of medicine, Para-Medical Workers of STD Clinics and other hospital and health functionaries and health educators.
- (ii) Officials of other sectors like teachers, extension officers, social welfare and developmental staff.
- (iii) NGOs operating in health and health related subjects.
- (iv) Professional and technical bodies, like IMA, IPHA, etc.,
- (v) Media personnel like T.V., AIR, Press, film makers, poets, writers, etc.,
- (vi) AIDS patients are potential excellent educators.

**4.4.** The success of health education also depends on the environment in which the educational process takes place. Identifying such settings and developing a favourable atmosphere in those places is necessary for a successful education. Such places are listed below:-

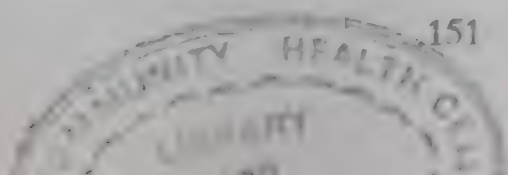
- (i) Hospital health education including education and counselling in STD Departments, screening and education in the blood banks, and education in other areas of the hospitals.
- (ii) Rehabilitation centers of intravenous drug users
- (iii) Rescue and rehabilitation homes of destitute women
- (iv) Community dwellings of high risk groups like red light area, migrant population, occupation groups, tourist and pilgrim centers, camp sites etc.,
- (v) Educational institutions and places of Youth congregations like hostels, youth homes etc.,
- (vi) Prisons and correction centers.



4.5. Appropriate educational aids to reach the community, and facilitate special campaigns are to be developed. AIDS education aims at behaviour modification that are very sensitive, highly personal sexual behaviour. Therefore, AIDS prevention messages need to be accurate, clear, consistent and realistic. It should not be alarming or otherwise cause sense of guilt. It should not be victim blaming, anti-sex or stigmatising. It should be self empowering. The same message need to be reinforced through a mix up of different channels. Examples of media channels include

- T.V. Spots
- Radio spots
- Cinema slides
- Posters
- Folders
- Magazines
- Newspapers
- Drama
- Puppetry
- Seminars, workshops, panel discussions
- Focus group discussions
- Messages on match boxes, key chains, T. Shirts, Bookmark
- Telephone hot lines
- Counselling of risk groups
- Runs and rally on Aids
- Competitions on messages, essay, drawings etc.,
- World AIDS Day held annually on 1st December is to serve to focus media and public attention on key issues and encourage politicians and other decision makers to maintain commitment of AIDS prevention programmes.

4.6. The educational strategies developed is to reach the community and risk groups. The approaches will broadly indicate the possible directions which have to be taken in planning, implementing and evaluating health promotion programmes about HIV transmission and AIDS. Mass communication channels with projected, electronic, print and display media to create general awareness will be the first stage of such approach. Simultaneously high risk groups, motivated people, groups of youths and women are to be approached, with suitable media, in small group communications. Interpersonal communication at individual level is most desirable. It enables doubt clarifications, confidence building and self empowering of individuals to fight against HIV



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infection. Doctors, Health Educators, Social Workers and other para-medical personnel are to be encouraged in educating HIV carriers, AIDS patients, their relatives and others clients.

5. To slow the epidemic and limit its devastating impact, there is an urgent need to step up interventions involving other sectors and ministries besides health, non-government organisation and the private sector. An integrated approach through the greater involvement and participation of community based organisations, including women's and youth groups, has a critical role to play in efforts to bring about behavioural change among individuals and to mitigate the challenges posed by AIDS.

At a world summit in London held during January 1988 to discuss a single subject "AIDS" 148 countries endorsed the consequent London declaration promising, "All in our power to ensure that our governments ..... Undertake .....urgent action" recognising that "the single most important component of national AIDS programmes is information and education".

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Development Projects have resulted in resurgence of Malaria in many countries. Sodevelopment projects shall have built-in anti-malaria, antivector programmes.

# 16 CHILD SURVIVAL STRATEGIES - AN APPROACH TO CHILD HEALTH

*Dr. S. Gopaul  
Dr. Prem Kumar  
Dr. Ravi Kumar  
Dr. Gita.*

## INTRODUCTION

Total paediatric care denotes preventive, promotive, educative, curative and rehabilitative care to the child. This is possible only by having a regular follow-up and making use of every available opportunity to talk to the mothers and impressing upon them the importance and significance of various health measures, 'Give a message - save a life', is a very good axiom to keep in mind. Doctors are in an important position as regards 'Health for All'. Exposure to knowledge will melt away the barriers of ignorance, prejudice and misconceptions people may have about health and disease, creating an awareness of health needs and problems and also of responsibilities on the part of the people. In the child Survival Health Care programmes, no other branch of medicine is so directly associated as social paediatrics is.

It is concerned with the delivery of comprehensive and continuous child health care services and to bring them within the reach of the entire community. Preventive paediatrics which is part of social paediatrics consists of two components 1. antenatal and 2. post natal. This study was intended to analyse the importance of regular follow up of children by the paediatrician and motivation of mothers right from the antenatal to the post natal period.

## MATERIALS AND METHODS

Fifty babies delivered at the Government Maternity Hospital, Madras and attending regular postnatal follow up in the paediatric clinic there (represented as Group -A) and fifty babies attending the general medical out-patient department at the Institute of Child Health for complaints other than ARI and diarrhoea, delivered elsewhere and not attending any regular follow up or well baby clinic were included in this study. All the babies were full term deliveries and weighing 2.5 Kg or more at birth. Their age at the time of interview/

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examination was between 1 to 1<sup>1</sup>/<sub>2</sub> years. A questionnaire was prepared and the mothers were interviewed to learn about 1. their socio-economic status 2. their educational status 3. their antenatal care during conception 4. the immunisation status of the children, 5. the mothers understanding of the specific significance of each immunisation 6. the practice of breast feeding the babies during the first 6 months of life and 7. the number of episodes of ARI and diarrhoea suffered by the child and hospitalisation, if any (due to ARI/diarrhoea) were noted. Family planning measures adopted by the parents was also noted. The children were then weighed and their mid arm circumference recorded.

The place of residence (katcha house and pucca house) was taken as an indicator of socio-economic status. Education beyond primary (5th standard and above) was taken as literacy. Atleast 3 visits to a doctor with a gap of atleast one month between visits and atleast 2 doses of tetanus toxoid antenatally were taken as criteria for satisfactory antenatal care.

All children given BCG, DPT and OPV (3 doses) and measles vaccine at the end of the first year of life were taken as fully immunised. Those who were given atleast one dose of any vaccine were included under partially immunised and those who had not received even a single immunisation were grouped under not immunised. Mothers who understood the specific significance of all the vaccines were grouped under 'fully understood'. Those who understood the significance of atleast 1 vaccine were grouped under part understood. Under breast feeding habit, children were categorised into those receiving breast feeds only without any artificial milk feeds/formula during the first 6 months of life and those on artificial milk feeds/formula with or without breast feeds. The 50th percentile of the ICMR reference standard of weight for age was used as the expected weight.

## RESULTS

Table 1 shows the age and sexwise split up of the children in the study groups.

It can be seen from Table I that there are a total of 24 male and 26 female children in group A. The number of children in the 1 year age groups is 19 and the number in the 1 to 1<sup>1</sup>/<sub>2</sub> year age group is 31 (in group A). Among children in group B there are a total of 26 males and 24 females and agewise there are 12 in the 1 year age group and 38 in the 1 to 1<sup>1</sup>/<sub>2</sub> year age group.

Table II shows the place of residence of the families of the children in the two study groups, which was taken as an indicator of their socio-economic status. In group A, 64% of the families reside in a 'katcha' house (tatched/tiled)

and 36% of the families live in a 'pucca' house. In group B, 78% live in a 'katcha' house and 22% in a 'pucca' house.

Table III compares the educational status of the mothers in the two groups. In group-A, 66% of the mothers were literate and 34% were illiterate. In group -B, 50% were literate and 50% were illiterate.

The antenatal care received by the mothers of the children in the two groups was evaluated and is shown in table -IV. It can be seen that in group -A 98% had satisfactory antenatal care and 2% unsatisfactory antenatal, care. In group - B, antenatal care was satisfactory in 94% and not satisfactory in 6%. These results may be viewed as comparable with regard to antenatal care received by these groups.

Table V shows the immunisation status of the children in both study groups. In group A all the 50 children were fully immunised (100%).

In group b 82% were fully immunised and 18% were partially immunised. There was no child who had not received even a single immunisation in both groups. The 100% immunisation status on the Group A may be due to their attendance at follow-up paediatric clinic.

The mothers understanding of the specific purpose and significance of each immunisation was analysed and is shown in Table VI.

In group- A, 38% of the mothers had fully understood, 46% had partially understood and 16% had not understood the specific significance of each immunisation. In group - B, 16% had fully understood, 14% had partially understood and 70% had not understood the specific significance of each immunisation. The higher knowledge level in group 'A' may be attributable to their attendance at the paediatric clinic.

Table VII shows the breast feeding of the babies in the first six months of life. In groups A, 98% of the babies were given only breast milk without any other form of artificial milk feeds/formula and 2% were given artificial milk feeds also. In group -B, 78% of the babies were given breast feeds only and 22% were given artificial milk feeds also with or without breast milk.

Table VIII shows the weight for age of the children in the study groups. In group- A all the 50 children (100%) were more than 80% of the expected weight for age. In group-B 76% were above 80%, 12% were between 70 to 80%, 6% were between 60 to 70% and 6% were less than 60% of the expected weight for age.

The comparative mid arm circumferences of the children in both the study groups is shown in table IX. In group A, 64% of the children have mid-arm circumference of 13.5 cms and above 36% have between 13.4cm to 12.5 cms



and none below 12.4 cms. In group \_B 22% have 13.5 cms and above, 58% have between 13.4 cm to 12.5cms and 20% have less than 12.4 cms.

Table X shows that in all children of 1 year age in group A (n=19) the average number of ARI episodes per child is 3 and the average number of diarrhoea episodes per child is also 3. There has been no hospitalisation in these children. In group B children of 1 year age (n=12) the average ARI episodes per child is 7 and average diarrhoeal episodes per child is 5. The total hospitalisations (due to ARI/diarrhoea) in this group is 4. In children between 1 to 1<sup>1</sup>/<sub>2</sub> years of age in group -A (n=31) the average ARI episode per child is 4 and the average diarrhoeal episode per child is 3. There has been no hospitalisation in these children. Among the group-B children between 1 to 1<sup>1</sup>/<sub>2</sub> years of age (n=38) the average number of ARI episodes per child is 7 and the average diarrhoeal episodes per child is 6. The total hospitalisation in this group (due to ARI/diarrhoea) is 12.

Table XI shows that in group-A, 90% of the parents adopted some form of fertility control measure and 10% did not undertake any such measure. In group - B, 48% adopted some form of family planning measure and 52% did not undertake any measure.

## DISCUSSION

It can be seen from tables that the two study groups are comparable with respect to the age and sexwise distribution of the children, the antenatal care received by the mothers during conception.

Immunisation is essential for child survival and child development; Of all life saving health services, immunization is the most simple and cost effective measure. But it can be seen from table V that only about 82% of the children in group - B have been fully vaccinated and about 18% have been partially vaccinated where as all the 50 children (100%) amongst those having a regular follow-up (group A) have been vaccinated, a statistically significant difference. It is however heartening to note that none of children studied were completely unimmunised.

In those mother's attending a regular follow-up (group A) 38% of the mothers knew the significance of all the vaccines, 46% understood the reason for atleast one vaccine and only 16% had no knowledge why they were being immunised. In comparsion to those not attending a regular follow up only 16% knew the purpose of all the immunisation, 14% understood partially and an astounding 70% had no idea as to the significance and purpose of even a single vaccine.



The uniqueness and importance of human breast milk<sup>3</sup> need no further stressing. From table VII, it can be seen that among the mothers attending a regular follow-up, 98% of them were continuing (group A) breast milk without any artificial infant milk formulas, till the first 6 months of life and only 1 baby (2%) was given artificial milk feeds. Whereas in those not having regular follow-up, only 78% of the mothers were continuing breast milk and 22% of them had already started artificial infant milk formula by the end of the first 6 months which is a statistically significant difference between the two groups.

Malnutrition in children is a major public health problem in India. It occurs particularly in weaning and children in the first year of life<sup>4</sup>. There is a direct correlation between malnutrition and infection and hence now-days the term triple-M (malnutrition - morbidity-mortality) complex is used.

It can be seen from table VIII that the weight for age of all the 50 children (100%) who attended regular follow up was above 80% of the expected weight for age whereas in those not attending a regular follow-up only 76% of the children were above 80% of the expected weight, 12% more mildly undernourished. (between 70 to 80%), 6% were moderately, undernourished (between 69 to 70%) and 6% were severely malnourished. This is a statistically significant difference. From table IX It can be seen that with regard to mid arm circumference also group - A children are better off than Group-B, with reference to their nutritional status. Nutritionist C. Gopalan has said that the incidence of protein energy malnutrition in India in preschool age children is 1-2%<sup>6</sup> and prevention at an early stage is vital for normal development during adult life.

Hence it can be seen from tables VIII and table IX that regular follow up and motivation go a long way in preventing malnutrition and promoting a better developmental outcome of the growing child.

ARI is responsible for 20-25% of mortality of under five children<sup>7</sup> and in an analysis of ARI by Dr. P.M. Udani in Bombay, the highest death rate occurred in the age group of 1 month to 4 years (about 40%)<sup>8</sup>. From table X, it can be seen that the average number of ARI episodes in a child attending the regular follow-up clinic is less than half that of the child not attending any follow-up. There is a statistically significant difference specially in the 1 to 1½ year age group.

Acute diarrhoea is a killer disease and more than 80% of these deaths occur in the first two years of life<sup>9</sup>. From table I, it can be seen that the average diarrhoea episodes per child in those not receiving any regular follow-up care

is almost double that of the children attending regular follow-up, Significantly so in the first 1 to 1½ years of life.

Table X also shows that the incidence of hospitalisation due to ARI or diarrhoea is about 16 in the group B whereas it is zero in the group-A. Hence to preserve and sustain a healthy life it is very essential have a regular follow up and motivation right from birth.

Birth spacing and family size are important factors in child growth and development. It is well known that child mortality increases when pregnancies occur in rapid succession. Studies have shown a lower IQ scores among children in larger families<sup>10</sup>. A WHO scientific group on the Health aspects of family planning has included infant and child health as one of the principal outcomes of family planning<sup>11</sup>. Family welfare is therefore an important means of insuring the survival of all children in a family. With this in mind it can be inferred from table XI (which shows that 90% of parents amongst those attending a regular follow up understood some form of fertility control measure as against only 48% in the other group) that regular care, good motivation, go a long way in promoting family welfare measures which indirectly promote child survival.

## CONCLUSION

Though the two group are comparable to some extent with regard to age and sex of the children and antenatal care status of the mothers, it must be reckoned that they are not actually matched on socio economic status, literacy. Hence the outcome with reference to immunisation, nutrition, disease incidence feeding habits and family planning which significantly vary in both the groups, has to be considered with these limitations. The group of babies attending regular follow-up care are definitely better off than their counterparts not receiving any follow up care. There has definitely been an upsurge in health awareness among the public but still the statistics shown are quite revealing with regard to certain aspects of health care.

Hence, regular motivation and regular health education regarding growth monitoring, oral rehydration, breastfeeds, immunisation, food supplementation fertility control (GOBIFF), during every contact with the mothers, who play crucial role in promotion of health of the children will go a long way in making the Child Survival Revolution- a resounding success.

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**TABLE-1**

### AGE AND SEX WISE DISTRIBUTION OF THE CHILDREN

AGE	A (n = 50) BABIES ATTENDING REGULAR FOLLOW UP		B (n = 50) BANIES NOT ATTENDING A REGULAR FOLLOW UP	
	MALE	FEMALE	MALE	FEMALE
1 year	9	10	7	5
1 year - 1½ years	15	16	19	19
TOTAL	24	26	26	24



**TABLE-II****SOCIO - ECONOMIC STATUS**

PLACE OF RESIDENCE	A (n = 50) BABIES ATTENDING REGULAR FOLLOW UP		B (n = 50) BANIES NOT ATTENDING A REGULAR FOLLOW UP	
	n	%	n	%
'KACHA' HOUSE (Thatched & Tiled)	32	64	39	78
'PUCCA' HOUSE	18	36	11	22

**TABLE-III****EDUCATIONAL STATUS OF THE MOTHERS**

	A (n = 50) BABIES ATTENDING REGULAR FOLLOW UP		B (n = 50) BANIES NOT ATTENDING A REGULAR FOLLOW UP	
	n	%	n	%
LITERATE (Primary & above)	33	66	25	50
ILLITERATE	17	34	25	50

**TABLE-IV****ANTENATAL CARE OF THE MOTHERS**

	A (n = 50) BABIES ATTENDING REGULAR FOLLOW UP		B (n = 50) BANIES NOT ATTENDING A REGULAR FOLLOW UP	
	n	%	n	%
SATISFACTORY (Atleast 3 visits and 2 doses of TT)	49	98	47	94
NOT SATISFACTORY	1	2	3	6

**TABLE-V**

**IMMUNISATION STATUS**

	A (n = 50) BABIES ATTENDING REGULAR FOLLOW UP		B (n = 50) BANIES NOT ATTENDING A REGULAR FOLLOW UP	
	n	%	n	%
FULLY IMMUNISED	50	100	41	82
PARTIALLY IMMUNISED	—	-	9	18
NOT IMMUNISED	—	—	—	—

p = 0.001

**TABLE-VI**

**MOTHER'S UNDERSTANDING OF THE SPECIFIC  
SIGNIFICANCE OF EACH VACCINE**

	A (n = 50) BABIES ATTENDING REGULAR FOLLOW UP		B (n = 50) BANIES NOT ATTENDING A REGULAR FOLLOW UP	
	n	%	n	%
FULLY UNDERSTOOD	19	38	8	16
PARTIALLY UNDERSTOOD	23	46	7	14
NOT UNDERSTOOD	8	16	35	70

p < 0.001

**TABLE-VII**

**BREAST FEEDING HABIT UPTO THE  
FIRST SIX MONTHS OF LIFE**

	A (n = 50) BABIES ATTENDING REGULAR FOLLOW UP		B (n = 50) BANIES NOT ATTENDING A REGULAR FOLLOW UP	
	n	%	n	%
BREAST MILK ONLY (without artificial milk feeds/formulas)	49	98	39	78
ARTIFICIAL MILK FEEDS/FORMULAS (with or without breast milk)	1	2	11	22

p = 0.001

**TABLE-VIII**

**WEIGHT FOR AGE OF THE CHILDREN**

	A (n = 50) BABIES ATTENDING REGULAR FOLLOW UP		B (n = 50) BANIES NOT ATTENDING A REGULAR FOLLOW UP	
	n	%	n	%
> 80 % (normal)	50	100	38	76
70 to 80 % (mild undernutrition)	-	-	6	12
60 to 70 % (moderate undernutrition)	-	-	3	6
< 60 % (severe undernutrition)	-	-	3	6

p < 0.001



**TABLE-IX****MID - ARM CIRCUMFERENCE OF THE CHILDREN**

	A (n = 50) BABIES ATTENDING REGULAR FOLLOW UP		B (n = 50) BANIES NOT ATTENDING A REGULAR FOLLOW UP	
	n	%	n	%
> 13.5 cms (normal)	32	64	11	22
13.4 to 12.5 cms (borderline)	18	36	29	58
2.4 cms (malnourished)	-	-	10	20

p &lt; 0.001

**TABLE - X****INCIDENCE OF ARI, DIARRHOEA AND  
HOSPITALISATION AMONG THE CHILDREN STUDIED**

	A (n = 50) BABIES ATTENDING REGULAR FOLLOW UP		B (n = 50) BANIES NOT ATTENDING A REGULAR FOLLOW UP	
	n	%	n	%
AVERAGE NO. OF ARI EPISODES PER CHILD	3	7	4	7
AVERAGE NO. OF DIARRHOEAL EPISODES PER CHILD	3	5	3	6
TOTAL NO. OF HOSPITALI- SATIONS (due to ARI/diarrhoea)	-	4	-	12

p &lt; 0.001

**TABLE-XI**

**FERTILITY CONTROL MEASURES  
ADOPTED BY THE PARENTS**

	A (n = 50) BABIES ATTENDING REGULAR FOLLOW UP		B (n = 50) BANIES NOT ATTENDING A REGULAR FOLLOW UP	
	n	%	n	%
YES	45	90	24	48
NO	5	10	26	52

$p < 0.00$

Immunisation campaigns achieve high initial coverage. But routine immunisation services are more cost effective. So it is better to put energies to strengthen routine immunisation services.

Road transport is the biggest contributor to air pollution. that put children at risk of development Chest infections and allergic Respiration diseases.

If malnutrition is widespread in the community, underweight and lethargic children look normal to parents who do not know healthy children behave.

WDR 1993.

# 17 LACK OF COMMUNITY AWARENESS AND PARTICIPATION RESULTING IN LOW UTILISATION OF M.C.H. SERVICES.

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## INTRODUCTION:

Due to more employment opportunities in towns and cities there is progressive migration of people from rural areas resulting in increase in urban population with concomitant growth of urban slums. Nearly 15% of the urban population live in slums. There is an increased effort by local self governments to improve the health status of slum population. MCH care in urban slums becomes the focus of attention in urban Health Services. Municipalities and Corporations are establishing number of Health Posts for providing MCH services to the slum dwellers. "How far these services are being utilized by them" and "what factors prevent them from utilizing these services" are important questions to be answered. There is a need for in-depth studies to answer these questions. Such study will help to plan proper educational and counselling strategies to improve the utilisation of urban MCH services.

With these objectives a study has been conducted in Coimbatore City Municipal Corporation. There are 142 slums scattered throughout the city. The slum population is 1,34,936 out of the total city population 8,97,709 (1991) Twenty MCH Centres with facilities for conducting deliveries are maintained by the Municipal Corporation. Out of these twenty centres, five centres have theater facilities for performing post-partum tubectomies and laparoscopic sterilizations.

## METHODS AND MATERIALS:

### 1. Questionnaire for study:

Closed type questionnaire was used for the survey. Relating to the reasons for their attitude in utilization of Corporation Maternity and Child Health

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Services, open ended questionnaire was administered to 100 utilizers and 100 non-utilizers; the reasons given by them were classified and based on that close type questionnaire was designed and pre-tested.

## **2. Interviewers:**

10 Public Health Nurses were used as interviewers after giving one day training to them.

## **3. Selection of slums for the study :**

The data relating to deliveries in Maternity and Child Health Centres for the year 1990 was used to rank the slums according to the number of deliveries occurred in Maternity and Child Health Centres from each slum . The slums at the two extremes i.e the slum with highest number of deliveries at Maternity and Child Health Centres and the slum with lowest number of deliveries at Maternity and Child Health Centres were selected for the study.

SLUM I-Slum ;in Selvasinthamanikulam: which shows the highest utilization.

## **SLUM II**

Slum in Erimedu-Sowripalayam road (Anna Nagar) which shows the lowest utilization.

## **4. No. of families in the study:**

House to house survey was conducted and all families were included in the study. 708 families in slum I and 623 families in slum II were covered. Out of 708 families in slum I, 9 families did not have women folk. In slum II, eleven families did not have women in their families:

## **RESULTS**

### **I. SOCIO ECONOMIC CONDITIONS IN RELATION TO UTILISATION:**

#### **OCCUPATION:**

Majority of the workers in both slums were unskilled workers (i.e) 92.4% in slum I and 86.8% in slum II, Skilled workers were 7.6% in slum one and 13.2% in slum two (Table D-1)

**TABLE D-1**

Occupation	SLUM I		SLUM II	
	No.	%	No.	%
1. Skilled workers	54	7.6	82	13.2
2. Unskilled labourers	654	92.4	541	86.8
Total:	708	100.0	623	100.0

x2=29.26

## 2. MONTHLY INCOME

Analysis shows that income of the family influences the pattern of utilization of Corporation Maternity and Child Health Services. In slum I, with high utilisation only 9.6 of the families have a monthly income of Rs. 500/-and above where as in slum II, with low utilization 17% of families have monthly income Rs.500/- above (table D-2).

**TABLE D-2**

Monthly income of family	SLUM I		SLUM II	
	No.	%	No.	%
Less than 500	640	90.46	526	82.9
500 and above	68	9.6	97	17.1
Total:	708	100.0	623	100.0

## 3. MOTHER'S EDUCATION

The results show that the percentage of women studied upto primary school including illiterate women is 87.4 % in slum I as compared to 80% in slum I. The percentage of women with secondary education and above is high at 20% in slum II Compared with 12.6% slum I (Table D-3)

**TABLE D-3**

Educational status of mothers.	SLUM I		SLUM II	
	No.	%	No.	%
Illiterates				
upto 5th Std.	611	87.4	489	80.0
6th Std. & above	88	12.6	123	20.8
Total:	699	100.0	623	100.0

**4. MOTHERS OCCUPATION:**

In slum I (high utilization slum) 92.9% of mothers are housewives and 7.1% of mothers were wage earners.

In slum II (low utilization slum) 88.7% of mothers are housewives and 11.3% of mothers were wage earners.

This difference is found to be significant and indicates a co-relation between occupation and utilisation of Corporation

Maternity and Child health Services (Table D4).

**TABLE D-4**

Mothers Occupation	SLUM I		SLUM II	
	No.	%	No.	%
House wives	649	92.9	543	88.7
Unskilled workers	48	6.9	61	9.9
Other jobs	2	0.2	8	1.4
Total:	699	100.0	612	100.0

x<sup>2</sup> = 9.07

**5. ANTE-NATAL CARE:**

The survey elicited information about the source of ante-natal care. Corporation Maternity and Child Health Centres provided ante-natal care to 36.7% of mothers in slum I and 31.6% of mothers in slum II.



## 6. NATAL CARE:

The information about the place of delivery was collected from each family for all the deliveries that occurred in that family. It is noticed that 18.6% of the deliveries in slum I and 26.6% of deliveries in slum II are home deliveries conducted by untrained persons (Table x).

**TABLE X**

Place of deliveries	SLUM I		SLUM II	
	No.	%	No.	%
MCH Centres	537	37.2	452	30.4
Government Hospital	590	40.8	509	34.2
Private Hospital	50	3.4	131	8.8
Home - UQ	268	18.6	392	26.6
Total:	1445	100.0	1484	100.0

## ATTITUDES IN RELATION TO UTILISATION:

### 1. Reasons for using the Corporation MCH Centres for Natal Care.

MCH Centres nearer to the slum and "Good ante-natal care and MCH Centre" are found to be the two significant factors which have motivated the mothers to come to Corporation MCH Centres. From slum II (with low utilisation) a high percentage of mothers have given the reasons for coming to MCH Centres, as "the centre is nearer" and "Free treatment is available". This explains that those who have used the Corporation MCH Services belong to very low income group of the slums. (Table AI).

**TABLE AI**

(Total mothers interviewed) :

Slum I - 689

Slum II - 577

Reasons for utilising MCH Centres for delivery care.	SLUM I		SLUM II	
	Yes	%	Yes	%
1. MCH Centre nearer	116	16.8	180	31.1
2. Free treatment	168	24.3	168	29.1
3. All facilities available	144	20.8	122	21.1
4. Good AN Care	96	13.9	108	18.7
5. Good delivery care	132	19.1	127	22.0
6. Visitors freely allowed	109	15.9	101	17.5
7. Facilities for family planning operation available.	58	8.4	57	8.1

(proportion test applied "MCH Centre - Nearer" and "Good AN Care are significant reasons.)

## 2. Reasons for not using the Corporation MCH Centres For Natal Care:

The study shows that the following are the significant reasons for non utilization of Corporation MCH Services.

1. Facilities are not available at MCH Centres.
2. Deliveries are not conducted by Doctors.
3. Only normal deliveries are conducted.
4. Facilities for family planning operation are not available.
5. Likes house deliveries.
6. Money available to spend.

In slum II higher percentage of mothers have given the reasons "NO facilities at MCH Centres", and "only normal deliveries conducted".

In slum II more than one-tenth of the mothers have answered that they like home deliveries. (Table A2).

**TABLE A2**

(Total mothers interviewed)

SLUM I -689.

SLUM II - 577.

Reasons for not utilising MCH Centre for delivery care.	SLUM I		SLUM II	
	Yes	%	Yes	%
1. MCH Centre distant	611	87.4	489	80.0
2. No facilities at MCH Centre.	117	16.9	126	21.8
3. Deliveries not conduc- ted by Doctors.	57	8.2	78	13.5
4. Only normal deliveries conducted.	124	17.9	138	23.9
5. Facilities for family planning operation not available.	27	3.9	43	7.4
6. Likes home deliveries	57	8.2	76	13.1
7. Money available to spend	12	1.7	32	5.5

(proportion test - applied. Sl. Nos. 2,3,4,5,6 &amp;7 are significant reasons).

3. Reasons for using the Corporation MCH Centre for under-going sterilisation operation.

293 mothers from slum I and 231 mothers from slum II have undergone sterilisation operation at Corporation MCH Centres or Government Hospital or Private Hospital. The following are significant reasons for availing sterilisation services at Corporation MCH Centre. (a) Motivated by ANM of MCH Centre. (b) Delivery has taken place at MCh Centre (Table A3).



**TABLE A3**

Total mothers interviewed SLUM I : 293, SLUM II : 231.

Reasons for using Corporation MCH Centre for undergoing sterilisation operation.	SLUM I		SLUM II	
	Yes	%	Yes	%
1. MCH Centre nearer	72	24.5	48	20.7
2. Motivated by ANM.	73	24.9	36	15.5
3. Motivated by Neighbours	35	11.9	41	17.7
4. Delivery at MCH Centre	53	18.0	57	24.6
5. To return home on the same day of Laproscopic camp.	23	7.8	11	4.7
6. Incentives are given at MCH Centre.	42	14.3	46	19.9
7. Good care at MCH Centre.	49	16.7	39	16.8

(proportion test applied - sl. No. (2) and (4) are statistically significant)

**4. Reason for not using the MCh Centre for sterilisation operation.**

In the study the following are found to be significant reasons for not using the sterilisation services available at Corporation MCH Centres.

(a) Corporation MCH Centres do not have facilities for sterilisation operation.

(b) Because of fear about the care at MCH Centre.

(c) Because of facilities like ESI and capacity to pay for the services of Private Hospitals.

(d) Because of delivery and sterilisation operation at mother's place.

The percentage of mothers who have given the reasons is higher in slum II than in slum I. (Table A4).

**TABLE A4**

Total mothers interviewed : SLUM - 293. SLUM II - 231.

Reasons for using Corporation MCH Centre for sterilisation.	SLUM I		SLUM II	
	Yes	%	Yes	%
1. MCH Centre distant.	25	8.5	23	9.9
2. No knowledge about MCH Centres doing family planning operation.	33	11.2	34	14.7
3. No facilities at MCH Centres	40	13.6	55	12.8
4. No good care at MCH Centres.	32	10.9	33	14.2
5. Fear about the care at MCH Centres.	16	5.4	30	12.9
6. E.S.I. and money to spend.	4	1.3	13	5.6
7. Delivery and operation at Mother's place.	22	7.5	5	2.1

(proportion test applied - reasons (3) (5) (6) and (7) are statistically significant)

## DISCUSSION:

An analysis of the data and a perusal of the results obtained shows that ;

(1) Socio economic differences appear to influence the pattern of utilization. The predominant groups which were found to utilize the corporation MCH centres are:

(i) Unskilled workers

(ii) Low income groups (Monthly income less than 500/-)

(iii) Illiterate women and women studied upto primary school.

(iv) Housewives who are not wage earners.

These socio economic groups constitute a high percentage in slum I. The percentage of skilled workers, studied upto secondary school and housewives who are wage earners is more in slum II than slum I.

2. The utilization appears to be influenced by “Institutional factors” as well as “worker factors”. Slum mothers come to MCh Centres if the distance to centre is less. They prefer to come for delivery if facilities for post-partum sterilization are also available in the same centre. Nearly one-fourth of the mothers of slum II have expressed that corporation MCH Centres can handle only normal deliveries and they do not have facilities for dealing with complications of delivery.

3. In slum I health workers have given ante-natal care to 36.7% of mothers. the percentage of deliveries which have come to centre is 37.2%. The percentage of home deliveries by unqualified Dais is 18.6%. In contrast to this in this slum II workers have given ante-natal care to 31.6% of mothers; the percentage of deliveries which have come to centre is 30.4%; the percentage of home deliveries by unqualified is 26.6%. “Good ante-natal care” is also found to be a statistically significant reason for mothers to come to MCH Centres. All these indicate that ante-natal registration, Good ante-natal care and counseling will bridge the gap between MCH Centres and “Low utilizing slums”.

Nothing much could be done relating to the influence of socio economic factors. But “Institutional factors” and “worker-factors” can be improved by way of upgrading the facilities, ensuring good antenatal care and involving the people in the programme.

## SUMMARY AND CONCLUSION:

The present study was conducted in Coimbatore City Municipal Corporation with the objective of understanding the extent of utilization of Corporation MCH Services,, the characteristics of the people utilizing the services and the reasons which prevent people from availing these services. One “high utilization slum” and another “low utilization slum” were selected for the study. Socio economic characteristics, MCH Services availed and attitudes of mothers were studied .

1. Socio economic factors appear to be relevant to the study in that economically weaker and educationally less accomplished section of the slum population appear to be relevant to the study in that economically weaker and educationally less accomplished section of the slum population appear to prefer Corporation MCH services more than the people who have educational and



economic advantages. The latter group of the slums prefer major hospitals or private nursing homes for normal deliveries. They have a wrong perception that the Corporation MCH Centres are meant only for very poor. This indicates that there is a need to create an awareness among these groups that Corporation MCH Centres have all facilities for conducting normal deliveries.

2. The slum dwellers expect the Corporation MCH Centres should also have facilities to manage deliveries with complications and facilities for post partum sterilisation .

3. In "low utilization slum", one-fourth of deliveries are home deliveries conducted by unqualified persons. This situation demands proper educational and counselling efforts in order to bring all deliveries to the institution.

4. Similarly service factors also appear to influence the utilization behavior of the people. They include;

- a. Nearness of the institution.
- b. Facilities available.
- c. Personal attention given by doctor.
- d. Volume of home visits made.
- e. Volume of antenatal registration done.
- f. Frequency and volume of antenatal services given.
- g. Personal rapport the worker develops with the families and community for their participation and utilization of the services.

5. Corporation is spending huge sums of money for establishment and maintenance of MCH Services. Such services will remain underutilized as long as there is no people's involvement and no interaction between workers and slum dwellers.

## **RECOMMENDATIONS:**

### **1. Location of the Centre and Clinic timings:**

Since it has been observed that time and effort required act as important barriers to avail the services actions need to be taken to remove these barriers.

MCH Centres may be located in the slums or nearer to the slums while planning future MCH Centres.

MCH Clinics should be conducted as close to the slum as possible.

The timings of the clinics should be made suitable to the slum dwellers.

### **2. Improved facilities:**

Slum mothers have expressed that they do not prefer Corporation MCH Centres because they can handle only normal deliveries and facilities for

undergoing post-partum sterilization are not available, which are found to be significant reasons.

So all Corporation MCH Centres need to be provided with adequate infrastructure to manage abnormal deliveries also. In addition to these Centres should have theater facilities for doing post-partum sterilization

Annexure 2 shows that more number of deliveries occur in those centres which have facilities for doing post-partum sterilization.

### **3. Influence through good service:**

Good antenatal care ensures positive utilization of Corporation MCH Services. So, MCH staff should make sincere efforts to register, examine and provide good care to all antenatal mothers in the slums. Mothers' experience will be positive if good treatment and follow-up are given.

The slum mothers think that the deliveries in the Corporation MCH Centres are not attended by doctors. In order to change this idea it is necessary that the deliveries may be conducted in the presence of doctors.

### **4. People's involvement:**

1. With the available infrastructure and good services a lot more could be achieved if attention is paid to health education measures and people's involvement ;in the MCH programmes. Slum mothers need to be informed about the need for quality MCH Care. The availability of services at Corporation MCH Centres should be made known to them. Efforts have to be taken to remove the fears about the quality of services in Corporation MCH Centres. Slum mothers must feel about the importance of antenatal care and delivery by trained persons and her decision should be supported by her family members and the community elders. All slum mothers should be aware of the need for immunization against vaccine preventable services and the availability of the immunization services in the MCH Centres. Wide and rapid diffusion of these ideas will be feasible only if the community is fully involved in all aspects of MCH Services . People's involvement is the only way to reach the "Hard-to-reach". Health workers should involve the slum elders in all MCH activities from the planning stage itself. The meeting for the community leaders should be conducted in the slums which will facilitate free exchange of ideas. Such free exchange of ideas will help to impress about the benefits of antenatal care, natal care and child care and the risks of home deliveries by untrained persons, to evolve solutions to the existing problems, to find ways to overcome obstacles, to fix the criteria of successful action and to find means to share the knowledge with other slum dwellers.

## **2. Health Communicators:**

People will trust and accept advice from the members of their own group more readily than they do from outsiders. The literate girls of the slums may be selected, trained for two days in community messages relating to health care. They can be used as "Health Communicators" in the slums. They will act as "Contact persons" during the slum visit of health worker for providing MCH services.

## **3. Model mothers:**

Satisfied acceptors can easily influence the other mothers and motivate them to avail quality MCH Care. Such satisfied acceptors can be called as "Model mothers". The following may be the criteria to call a mother as Model Mother.

1. She had A.N. Care during her pregnancy.
2. She had T.T. Immunisation during her pregnancy.
3. Her child is fully immunized.
4. She had adopted one of the family welfare methods.

The selected "Model mother" can be given a certificate as a mark of recognition. They may be given two-day training about the basic aspects of MCH Services so as to communicate the ideas to other mothers in the community.

## **4. Mother classes:**

Since group influence play an important role in motivation, efforts need to be taken to change the whole group rather than just one individual. "Mother class" is a very effective forum to influence the decision of mothers. Mother classes can be conducted once in a week in Corporation MCH Centres. The group discussion with the mothers can be used to clarify their doubts and fears and they can be guided to take proper decisions about AN Care, place of delivery and infant care. Nutrition demonstration can also be done in the mother classes which will help to improve the nutritional status of women and children.

These recommendations will maximize the utilization of MCH Services by slum dwellers. The large amounts spent by Corporations and Municipalities for the Health Care of slum population will become justifiable expenditure in terms of the improvement in the Health status of women and children.



## ANNEXURE - I

### Coimbatore city - Slum population (Enumerated)

S.No.	Name of the MCH Health Centre	No.of Huts in slums	Population in slums
1.	Seethalakshmi Maternity Home	1269	8066
2.	C.T. Maternity Home	3436	12123
3.	V.V. Maternity Home	1323	7669
4.	R.K. Bai Maternity Home	3050	13006
5.	Singanallur Maternity Home	721	3862
6.	Selvapuram Maternity Home	2298	14631
7.	Meenakshi Maternity Home	1242	6396
8.	Raja Street Maternity Home	441	3128
9.	Ramanathapuram Maternity Home	1352	7481
10.	Jail Road Maternity Home	1281	6723
11.	Pattunool Maternity Home	166	1892
12.	Nanjundapuram Maternity C.N. Centre	1165	7547
13.	Peelamedu M.C.H. Centre	720	3834
14.	K.K. Pudur M.C.H. Centre	519	2112
15.	Uppilipalayam M.C.H. Centre	484	2192
16.	Telengupalayam M.C.H. Centre	473	1503
17.	Sowrripalayam M.C.H. Centre	917	3728
18.	Ganapathy M.C.H. Centre	1569	8450
19.	Rathinapuri M.C.H. Centre	2986	17572
20.	Seeranaickanpalayam M.C.H. Centre	522	3021
Total:		25934	134936

## HEALTH EDUCATION: NEW APPROACHES

Many policy-makers and governments have gradually come to understand that men and women-every man and every woman-are capable of being actively involved in matters regarding their own health, provided that they are aware of the issues involved, or the resources available. The concept obviously requires a change of attitude not only among the individuals themselves but among those who provide health care. Experience has shown that paternalistic approaches and the imposition of decisions upon others are seldom effective.

- \* The modern concept is that the role of health education is one in which the health care providers and the people both teach each other and learn from each other, changing roles constantly. Far from merely seeking the cooperation of communities in carrying out plans already made, health education should aim at encouraging people to be actively involved in the planning and maintenance of their health care system and to act in partnership with health care providers.
- \* Health Education objective is to foster activities that encourage people to be healthy; to know how to stay healthy; to do what they can individually and collectively to maintain health; and to seek help when needed.

*WHO Expert Committee, Technical Report Series 690-  
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We often talk about 'women need this, women need that'. We shouldn't underestimate women; they know what they need and want. It is not our place to impose a decision on any woman. It is for us to make the opportunity available to women so that they can make the choice. This includes having family planning and health services available at times that are convenient, at places that are nearby and provided by people who are appropriate and acceptable.

— Sandra Kabri  
Bangladesh Women's Health Coalition



# 18 NEED FOR COMMITMENT AND INVOLVEMENT OF PARENTS IN THE FEMALE CHILD PROTECTION SCHEME.

*Dr. V. Natarajan.*

## INTRODUCTION:

A glance at the title of this paper may appear paradoxial in that it may imply that the parents in general are not committed to protect their female offspring which we know is not true. However, a reading of the following news item and the discussions that follows may underline the truth of this statement, of course to a limited extent both in time and territory.

The news item (1) in question entitled "Another baby left in the cradle" reads "The Government Medical College Hospital here (Salem) received a four day old female baby" - the parents of the baby came to the Hospital and left the baby in the cradle, placed in the hospital under the special scheme announced by the Chief Minister of Tamil Nadu to protect the female children.

By now such a news has become more frequent and is becoming an accepted phenomenon by the community. Thus it becomes evident from the fact that the parents in question no longer shy away from letting their identity known to others in their community and outside.

But for this scheme the female baby in question would have slept in her early grave having been done to death by her own parents as was the fate of several unfortunate and unwanted female children.

From the above account it may not be constreved that the practice of the female infanticide is widely prevalent in Tamil Nadu and also the thinking that this 'Cradle baby scheme' is the ideal solution to it.

In this paper an attempt is made to learn the magnitude of the problem and the extent to which the 'Cradle baby scheme' would help to solve this problem apart from exploring the possible alternative strategies that may help in fighting this problem.

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Dr. V. Natarajan. Social Psychologist, Directorate of Public Health and Preventive Medicine, Madras - 600 006.

## METHOD:

In the absence of any reliable survey on the magnitude of the prevalence of the practice of female infanticide, it was decided to rely upon the registered neonatal deaths under civil registration scheme, with sexwise and districtwise distribution for a consideration of the same. The assumption being that if it is not influenced by any other intervening factors, the ratio of male and female neonatal deaths should be around 1:1.

Further supportive evidence of likely prevalence of this practice was obtained through interview of health staff at the village and nearby referral health facilities in some parts of Dindigul Anna and Madurai Districts.

Cursory observational data relating to the growth and development of the children left behind by their parents was obtained from a reception centre functioning under an I.C.C.W. project in Usilampatti town, Madurai district.

Data relating to the possibility of saving such babies and persuading their parents to bring up their children was collected from an interview of the field functionaries working under the I.C.C.W. project project and the records and registers kept in the centre.

## RESULTS:

The proportion of neo-natal and post-neonatal deaths appear t be almost equal for either sex among all the districts in Tamil Nadu excepting the districts of Salem, Madurai and Dharmapuri where the female infant deaths appear to be more than twice to that of male neo-natal deaths. In Dindigul Anna District the difference in the proportion of male female neonatal deaths is only marginally high for female infants (See Annexure-1, Table 1&2).

The interview data also suggest the prevalence of the practice of female infanticide in some parts of Periyakulam Taluk of Madurai District, which reveals that the practice is only confined to certain pockets of Madurai district. Even in Periakulam Taluk also it was stated that the practice is confined to the dry belt where the area is not served by Vaigai river irrigation system. From the above results and observations it may be inferred that the disproportionate female neonatal deaths found in these districts may in part be due to the reported practice of female infanticide.

Even among these districts viz. Salem, Madurai and Dharmapuri, the average ratio of male neonatal deaths to that of female neonatal deaths for the four years from 1989 to 1992 works out to an abnormal high of 1:2.9 for Salem, 1:2.41 for Madurai and 1:2.28 for Dharmapuri. In Salem district the ratio appears to have increased from 1:2.68 for the year 1989 to 1:3.14 for the



year 1991 and thereby shows a marginal decline to 1:2.93 for the year 1992. The decline in the disproportionate female infant deaths in Salem during 1992 though appear to be marginal yet can be taken as a significant one because the decline was registered when compared to otherwise an increasing trend. This decline, which has to be watched and followed up may be attributable to the 'Cradle baby scheme'. This view gets strengthened by a corroborative decline in the adjoining district of Dharmapuri whereas in the Madurai District, where the cradle baby scheme is not introduced and which is away from Salem District, there seems to have an increasing trend even during 1992, the year in which the proportion registered an abnormal high of 1:3.31 (See tables 3.1, 3.2, 3.3 and 3.4 of Annexure I) From the above results it may be inferred that the 'Cradle baby scheme' implemented in Salem District appears to have some beneficial effect in the form of decline in the proportion of female neonatal deaths not only in Salem District but also in the adjoining Dharmapuri District.

### **Condition of the babies living in the reception centre:**

A visit to the reception centre run by an I.C.C.W. project located in Usilampatti and a discussion with the staff there revealed that the centre had seven infants as inmates (See list 1 of Annexure I) ranging in age from few days to over an year. From the list it can be seen that excepting in the case of one child named Brindha, whose percentage was known, others were received as abandoned children. Compared to this, their Newspaper report mentioned at the beginning which reveals the identity of parents may be considered as a long way towards the acceptance of 'Cradle baby scheme' without the fear of any social stigma.

Considering the state of the care of these children it has to be stated that the staff incharge of the centre, some of whom stay as inmates, appear to provide good care for the babies including the provision of toys and dolls. They even appear to play with and fondle the children apart from feeding them and taking care of their needs regularly. The children who were also named and being addressed by their names appear to be well looked after.

Despite such a detailed attention and care the older children appear to be dull and somewhat sickly may be due to a lack of mothers' warmth, love and affection apart from breast feeding. On further probe the staff also unreservedly agree that these children would be better off with their mothers and informed further that their project and work also encourages mothers to keep their female babies alive and bring them up. The staff provided a list of 62 such babies saved by the field staff. (The list of these babies is available with the author) It was reported that these parents especially the mothers who were given good antenatal care and with whom the workers developed a good rapport were



persuaded to retain and rear their female babies born to them with proper counselling and promises of Government support and aid.

From the above account it maybe inferred that it appears possible for the field staff(village level) like the Animators, Anganvadi workers and the village Health Nurses to identify these parents who are likely to do away with the baby to be born if it happens to be female one and to persuade them over a period while providing antenatal care to retain the baby alive and to bring it u by the parents themselves with the promise of further support from the Government.

## **DISCUSSION AND CONCLUSIONS:**

The practice of female infanticide has been found to be present in some parts of Salem, Madurai and Dharmapuri districts in Tamil Nadu. Such a practice though abhorring is not peculiar or confined to Tamil Nadu alone. It was reported to be in vogue in several parts of the world mostly among the less fertile regions and who are nomads / wanderers / hunters etc. for reasons of economic sustainability. Even in our country it was reported to be widely prevalent in Rajasthan and Punjab during Pre-independence days. But all over the world the practice appears to have declined with the advancement of civilization (2).

This is not to justify the practice of female infanticide which appears to exist in certain parts of Salem, Madurai and Dharmapuri districts of Tamil Nadu, but to learn the conditions which appear to sustain the practice.

From this preliminary study the practice appear to be a sequel to the conditions of poverty, and the social economic burden of bringing up the female babies and marrying them off. Detailed studies may be desired to learn and isolate such conditions which help to perpetuate the practice.

However, even with the present level of limited understanding it is heartening to note that many of these people (parents) appear to be reasonable and get persuaded to abstain from this highly detestable practice.

It is also seen in the families where the loss of female baby is reported they already have more children than the family's economy could sustain. From this point of view an additional child becomes an unwanted and a disposable one in the interest of the rest of the members of the family. This view gets supported from an earlier study by the author (3) in which it was observed that more women seek assistance for induced abortions by dais in some parts of Salem district. If this be so which may be confirmed from studies on abortion deaths, there is a very strong case for promoting birth control practices in these communities. Meanwhile the cradle baby scheme may be

considered as the desired intervention in dissuading the people from indulging in female infanticide. As already stated in the beginning the scheme is gaining in acceptance as the most desirable alternative in the existing conditions. Now the parents seem to be willing to disclose their identity while leaving their babies in the cradle which was not the case to begin with. This is a good augury.

In the longrun it appears to be more practicable and feasible to educate and persuade mothers to retain and rear their female children by closely working with them especially during their period of pregnancy and by offering support services including family limitation practices. With this type of positive approach and by working with the parents and in counselling them, it is hoped that the parents commitment and involvement could be obtained in bearing and rearing their female child with some support from Government.

## **CONCLUSION:**

1. Female infanticide appears to be present in certain parts of Salem, Madurai and Dharampuri districts in Tamil Nadu.
2. The cradle baby scheme appears to gain acceptance among the parents who willingly come forward to deposit their additional female babies in the cradle kept under this scheme.
3. These parents appear to be amenable to reasons and get persuaded to retain their female child and to bring her up if properly counselled and reassured of the available Government assistance. This it is best done by the staff who provide antenatal care provided their visits were frequent and services useful and timely and their efforts sincere and if they try to counsel parents in a climate of personal rapport and involvement.

## **RECOMMENDATIONS:**

1. In view of the present level of understanding it is felt that the cradle baby scheme appears to be a good alternative to stem the practice of female infanticide and should be continued.
2. In the longrun a scheme to counsel the parents to bear and rear their female children apart from limiting their family sized should be considered and strengthened.

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# NEONATAL DEATHS REGISTERED UNDER R.B.D.ACT, 1969

	1989		1990		1991		1992	
	M	F	M	F	M	F	M	F
CHENGALPATTU - MGR	233	181	212	176	245	186	144	115
COIMBATORE	146	115	118	100	92	65	102	81
DHARMAPURI	57	59	36	68	47	123	50	125
KANYAMUMARI	116	97	103	66	115	84	77	63
MADURAI	190	416	276	550	232	579	181	515
NORTH ARCOT - AMBETHKAR	260	237	274	302	265	302	262	267
T.V. MALAI SAMBUVARAYAR	433	348	374	298	311	259	253	219
PERIYAR	156	168	135	115	114	110	133	117
PUDUKOTTAI	14	12	26	18	20	34	19	31
RAMANATHAPURAM	34	27	28	22	25	37	20	32
SALEM	369	901	335	877	372	1090	456	1238
SOUTH ARCOT	920	678	805	653	691	591	649	574
THANJAVUR	274	183	221	167	200	143	23	19
NAGAPATTINAM - QM	0	0	0	0	0	0	129	101
THE NILGIRIS	23	22	23	24	29	34	21	24
TIRUCHIRAPALLI	178	173	183	194	167	149	143	144
NELLAI KATTABOMMAN	84	73	88	75	92	68	76	55
KAMARAJAR	85	77	78	89	67	76	80	81
PMR - THEVAR	25	15	20	24	27	24	21	27
DINDIGUL - ANNA	181	211	183	185	101	135	157	202
CHIDAMBARANAR	50	26	35	31	30	24	28	21
TOTAL	3828	4019	3553	4034	3242	4113	3024	4051

# NEONATAL DEATHS REGISTERED UNDER R.B.D.ACT, 1969

	1989		1990		1991		1992	
	M	F	M	F	M	F	M	F
CHENGALPATTU - MGR	190	141	194	167	184	139	82	67
COIMBATORE	99	97	91	75	58	44	63	60
DHARMAPURI	36	38	20	45	27	96	35	90
KANYAMUMARI	84	59	59	40	77	48	57	33
MADURAI	171	377	266	536	197	500	125	414
NORTH ARCOT - AMBETHKAR	173	146	185	201	165	213	175	184
T.V. MALAI SAMBUVARAYAR	270	232	256	196	176	163	159	125
PERIYAR	133	152	131	113	92	92	108	86
PUDUKOTTAI	11	8	16	8	12	23	14	21
RAMANATHAPURAM	22	10	19	10	13	21	11	14
SALEM	258	692	245	692	276	867	337	986
SOUTH ARCOT	540	361	485	353	381	334	362	312
THANJAVUR	189	112	145	112	140	98	20	16
NAGAPATTINAM - QM	0	0	0	0	0	0	86	70
THE NILGIRIS	14	12	16	18	23	25	17	17
TIRUCHIRAPALLI	108	95	104	113	117	113	94	95
NELLAI KATTABOMMAN	59	48	56	57	58	38	58	38
KAMARAJAR	53	33	49	49	46	39	48	57
PMR - THEVAR	16	10	13	11	14	12	15	16
DINDIGUL - ANNA	157	181	177	183	88	125	113	146
CHIDAMBARANAR	31	12	23	18	18	13	21	14
TOTAL	2614	2794	2550	2997	2162	3003	2000	2861

## Sexwise Neo-natal deaths for four years.

### 3.1 Salem District:

YEAR	MALE	FEMALE	PROPORTION
1989	258	692	1:2.68
1990	245	692	1:2.82
1991	276	867	1:3.14
1992	337	986	1:2.93
Total :	1116	3237	1:2.90

### 3.2 Madurai District:

YEAR	MALE	FEMALE	PROPORTION
1989	171	377	1:2.20
1990	266	536	1:2.02
1991	197	500	1:2.54
1992	125	414	1:3.31
Total	759	2827	1:2.41

### 3.3. Dharmapuri District:

YEAR	MALE	FEMALE	PROPORTION
1989	36	38	1:1.06
1990	20	45	1:2.25
1991	27	96	1:3.56
1992	35	90	1:2.57
Total	118	269	1:2.28

### 3.4. Dindigul Anna District:

YEAR	MALE	FEMALE	PROPORTION:
1989	157	181	1:1.15
1990	177	183	1:1.03
1991	88	125	1:1.42
1992	113	146	1:1.29
Total	535	635	1:1.19



## ANNEXURE-I

### List 1

#### List of children at the reception centre, Usilampatti.

1. Abinya, C/o. Karupayee, Andipatti Bangalow.
2. Archana, C/o.Sangarammal, W/o.Kandasamy, Kattaipatti.  
C/o. Dr.Chitra Devi.
3. Aparna, C/o.Kothaisamy, Bothampatti.
4. Abitha, C/o.Nagarani, Usilampatti.
5. Brinda, D/o. Pandi, Melapudur.
6. Beena, C/o.Rajam, Supt Govt Hospital, Usilampatti.
7. Cheema, -do- -do- -do-

The number of women entering marriage and the childbearing period will increase by one-third during the 1990s. Unless we succeed increasing contraceptive use, we may well have more maternal deaths during this decade than in any decade in history.

—Dr. Malcom Potts  
Family Health International

Too many women live under deplorable conditions simply because they are women. Women have lower legal status than men, and they are treated as inferiors in culture and religion. They are barred from most economic opportunities and they are underpaid in those left open to them.

—Dr. George Zeidenstain  
The Population Council

## *Section 3*

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### *Communication*





# 1 Role of Communication and Media and Promoting People's Involvement with special reference to interpersonal and group approach.

*K. Kaliyaperumal*

## INTRODUCTION

Communication is an integral and important component of the total health programme. As stated by the WHO Expert Committee (TRS 690) 'if people are to fulfil their roles in primary health care, they have to be well informed, and this is an important function of health providers and the mass media. Both have a major role in (a) Enlightening the population on the prevailing health problems in the community and informing the people about the most appropriate methods of preventing and controlling those health problems and b) providing information on alternative types of behaviour and their outcomes so that individuals can make an informed choice and accept the consequences.

**Communication process:** Communication is the process of transmitting meaning between individuals. This process has been going on ever since the dawn of history. It is vital for the progress of society. Early man communicated through symbols and gestures and later on the spoken word, in the form of language, was used for communication. As technology developed, written words and other media were used, in addition to the symbols, gestures and spoken words. Every symbol and gesture had a meaning in the primitive times. Even today they carry meaning and have an important place in the communication process.

**Communication for social change:** To day we realise the crucial role of communication in developmental programmes as a catalyst of social change. It has been said that communication is the back bone of modern societies.

**Communication is a means to mobilise people:** The importance of information and communication in mobilising the people and seeking their willing cooperation in political, social and economic development is well recognised.

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## Communication approaches

People vary in their life styles and the level of knowledge. An uniform communication approach therefore may not be suitable. So, a mixture of different approaches must be used, depending upon the local conditions. These could be classified as:

1. Individual approach
2. Group approach
3. Mass approach

Each approach has its own advantages and limitations depending on the purpose and situation.

For interpersonal and group approaches, appropriate methods and media have to be selected depending upon the community and content of the messages. It is also better to find out already existing communication channels, and level of information through KAP study. Based on the KAP findings, the worker has to select methods and media suitable in promoting people's involvement with special reference to interpersonal and group approaches. Common methods and media which are suitable for Rural Areas for interpersonal and group approach are given below:

### Methods and Media for Group and Interpersonal approach

Communication approaches	Method	Media
1. Group approach cussion	1. Group dis-	1. Film
		2. Tape Recorder
		3. TV
	2. Demonstration 3. Role play	4. Video
		5. Flash Card
		6. Flannel graph
		7. Puppet show
		8. Flip Book
		9. Book-lets
		10. Leaflets
2. Individual approach	1. Home visit 2. Individual contact 3. Counselling	1. Photo folder
		2. Book-lets
		3. Leaflets
		4. Kits
		5. Flash card
		6. Models

Both mass media and interpersonal communication have their individual and complimentary roles. Information transmitted by media carries a certain amount of prestige; Interpersonal communication helps to reach deeper into the attitudinal and motivational core of the individual. It also helps in decision making process and to solve psychological problems, feed-back is possible in interpersonal communication. When both are combined the chances of influencing people to take appropriate actions are greatly increased. Mass communications cannot replace face to face approaches.

Each has its definite and well defined objectives. Mass media programmes are best followed up with the affective system of interpersonal communications. So that awareness can be converted into actions without any lapse of time.

## **Role of Media**

The materials used for communicating any message may be referred to as media. It may be an object, substance, instruments or system used for transmitting messages.

Media make the communication situation most effective and has social responsibility in the developmental process.

It has been widely documented that a single communication channel cannot adequately convey the entire communication content effectively. So multi media approaches are likely to work best in reaching the target audience and reinforcing the messages.

The main role of media is to generate interest, provide information, change attitude and stimulate, action.

There are many types of media and they are generally classified as modern and traditional.

Modern media can be broadly divided into two categories viz. mechanical and printed. Mechanical/ electronic media are T.V., Radio, film and tape recorder, The Print Media are newspaper, magazine, book, poster, folder, leaflets and hoarding. Traditional media are further classified into folk media and classical media.

## **Linkage of Modern Media with Traditional Media**

The modern media like T.V. and Radio realising the importance of Folk media are using them as channel of communication for disseminating the messages for example puppet show, Therukoothu, villupattu in the T.V. programmes.



## **Role of communication and Media in promoting people's involvement**

Success of the Health programmes depends upon the involvement of the people. If Health workers are creating or providing a situation, people will change themselves. We do not educate people, nor do we change people. People educate and change themselves. The communicator provides situations for people to change or educate themselves. So Communication is the link between the health providers and the community.

If community participation is the heart of the primary health care, communication is the blood. Through communication process people can be involved as active partners for accepting Health care service. When we involve the people effectively in planning, implementation and evaluation of any health programmes, there will be better understanding and effective utilisation of Health Services.

The communication strategies followed by Gandhigram Institute of Rural Health and Family Welfare Trust, in promoting people's involvement with special reference to interpersonal and group approaches are as follows:

1. Training of Community leaders
2. Training of Mather Sangam (mothers club)
3. Training and working with Traditional Birth Attendants
4. Training and working with indigenous medical practitioners.
5. Use of satisfied adopters.
6. Involvement of other sector personnel like Teachers Gramasevaks, Postmasters, animators,
7. Providing recognition and restimulation of the leaders.
8. Conducting Educational session in small groups by utilising the trained leaders and
9. Individual contacts.

**The strategy developed by GIRH & FWT in promoting peoples involvement for Health and MCH programmes are given below:**

1. Identification of community leaders, and training them and creating a sense of responsibility for carrying out the programmes in their communities.

It was assumed that for individuals to practice any health behaviours, they must have correct information from a person or organisation whom they trust, services within the easy reach and social support for the acceptance of the programmes. Based upon these assumptions, a set of operational principles and methods were evolved by the Institute to guide the efforts of health workers in promoting community health and family planning programmes is given below:

1. Responsive villages were taken up for the development of programme to begin with.
2. Social sanction was created through the interested and influential community leaders representing all communities / caste groups.

It was obtained through the

- i. identification of interested and influential leaders in the community.
  - ii. organising orientation training to enable them to educate their own community and reach target groups.
3. Providing adequate support and help them, to take up the responsibilities.
  4. Forming of a village Health Committee consisting of leaders and making it to meet periodically; review the progress and plan further programmes.

## **Training of Community Leaders**

One-day orientation training camps were organised for the men and women leaders (20-25 from each village) Separately either at the block headquarters/primary health centre/sub-centre/village itself. In these camps the leaders were provided with the programmes and the roles the leaders could play were discussed. The participation of the staff of Community Development block and the primary health centre helped the leaders to explore the possibility of meeting some of their priority needs besides creating rapport between the workers and leaders.

### **The objectives of there camps were:**

1. to discuss with community leaders, the health problems and advantages of small family norm;
2. to provide information regarding various programmes and develop skills in carrying out educational activities in their villages;
3. to discuss the ways and means for implementing the health programmes in their villages; and
4. to determine the roles of leaders and plan with them further course of action.

Different educational methods viz. Group discussion demonstration and role play and different media like; flash card, filmstrip film photo folders and models were used to provide information and to stimulate interest among the participants.

Following the leaders' training, educational sessions were conducted in the village itself for the villagers (men and women) in small groups utilizing the trained leaders.

Separate orientation training camps in Health and Family Planning were also conducted for traditional birth attendants, indigenous medical practitioners, school teachers, members of women's associations, youth clubs and Panchayat members.

### **Mothers club :**

The Institute also used the Matharsangams (Mother's club) as a forum for educating mothers on various health and family planning programmes. The Auxiliary Nurse Midwife and Health Visitor having established good rapport with the office bearers were able to obtain support of mothers in implementing MCH, Nutrition and Family Planning programmes. Some of them after adopting a family planning method served as example setters and shared their experiences as satisfied adoptors with other women. They helped the health workers in carrying out health programmes in their villages. Some served as Depot holders for distributing Nirodh and motivated mothers for accepting family planning.

### **Traditional Birth Attendants:**

The traditional birth attendants who are very popular and influential among village women as they provide MCH services in remote villages were utilised as an effective channel of communication. They were utilised to educate mothers on health and family planning and provide certain MCH services. They also served as depot holders for distribution of nirodh to eligible couples.

### **Indigenous Medical Practitioners**

The indigenous medical practitioners were involved in implementing health and family planning programmes, after an orientation training. They reside in the village and provide treatment to the villagers, who have faith in native medicine. Their active cooperation was enlisted for provision of certain services like functioning as Depot holders- for distribution of Nirodh, referring cases for family planning, reporting births and deaths, epidemic intelligence and reporting any cases suffering from communicable diseases and helping the workers in taking control and preventive measures.



## **School Teachers:**

The school teachers were involved in implementing health and family welfare programmes in the villages. They disseminated knowledge on health and family planning among the villagers especially the parents of their school children. Some volunteered to serve as Depot holder, provide follow-up care for family planning adoptors and inform the health staff regarding potential acceptors of family planning methods.

## **Individual contacts:**

Through individual contacts the workers cleared their doubts and dispelled their fears of the individuals in respect of health and family planning programmes and particularly in respect of contraceptive methods which could not be discussed in group discussions due to shyness. During such contacts, the workers were able to find out receptive, not so receptive and resistant groups. Subsequent visits were directed towards the receptive group to create a few satisfied customers. This helped to reduce the resistance and convert some of the not-so-responsive into responsive.

## **Providing Recognition and Restimulation to the Leaders:**

Once or twice a year the leaders were brought back for a one-day reunion camp to exchange successful experiences, discuss problems, assess progress, plan for future. This practical learning opportunity usually gave a boost to the programme.

The use of this method in an immunization and F.P. programmes successfully is described hereunder.

## **Success story of Triple Antigen programme in Athoor Block in 1960**

The main objective of this programme is to immunise all children in the area from 3 months to 5 years with 3 doses of triple antigen.

A programme was first started as part of paediatric clinic in April, 1960. By this method, the target achieved was very low and slow. Only 20% of children were given all the 3 doses of immunisation. Another method was tried by giving triple Antigen immunization for all the children attending the O.P. in the Primary Health Centre at the rate of 10 per day.

A third method tried in 1962 was using community education approach, the village leaders were involved in planning and execution of the programme.

After giving information, the leaders listed out the eligible children, educated the parents on the need and benefits of such Immunisation, collected the children for all the three doses and followed up. This method was found very effective from the point of view of coverage and minimising the drop outs. (90% coverage)

## **Family Planning**

Our Experiences show that running family planning clinics with social workers was found to be expensive and not very effective. In order to cover the low income segment of population, a different approach was tried in 1962 in Gandhigram Institute of Rural Health and Family Welfare Trust using interested and influential community leaders for Family Planning Programme. The leaders so chosen by the people were given training in family planning for a day.

After knowing different family planning methods, some were chosen to serve as depot holders to supply conventional contraceptives. It facilitated any person to get his required supply without any physical or psychological barrier in the village.

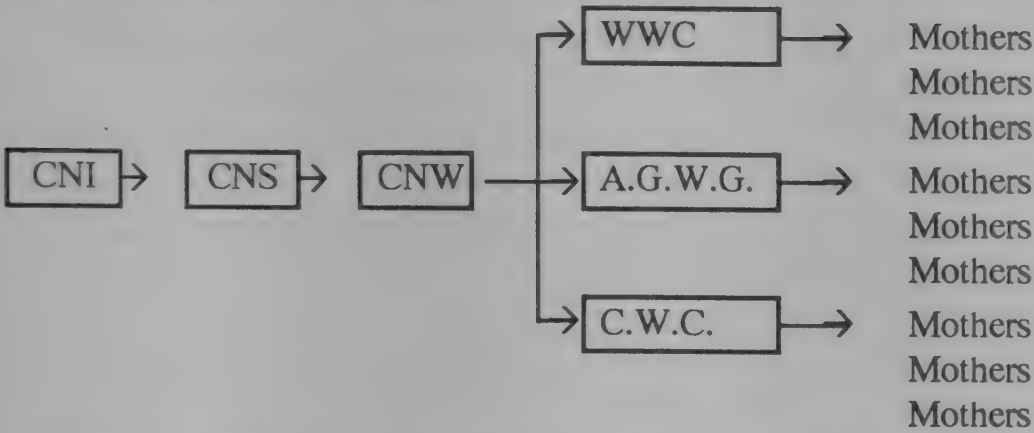
The educational approach adopted was based on the general principles of community organisation. A judicious combination of individual and small group discussions, utilisation of interested and influential leaders in the village to take responsibility in planning and implementing programmes, individually and through committees resulted in 24.6% of eligible couples accepting one or other F.P. methods in Athoor Block (1977)

### **ii TINP Communication strategy**

The communication strategies followed in Tamil Nadu Integrated Nutrition project are reaching the mothers through women's working group (WWC) adolescent Girls working group (AGWG) and children working group (CWG).

The Grass Root level workers have identified and created many channels of communication like women's working group Adolescent Girls Working group and children working group. Since they are locally available, they can provide need based information and services at the appropriate time.

# TINP Communication strategies



The interest of the groups was sustained by regular meetings and cooking demonstrations arranged twice a month.

Special sessions were organised for the Presidents of the women groups. In some cases, women’s groups were encouraged successfully to establish production centres for preparation of feeding supplements using locally available cereals and pulses. Apart from their value in generating income for the group, the activity provided an ideal situation for conveying health and nutrition messages to the community through their own people. There has been much talk about the need for drawing women into the main stream of development activities. The TINP Project however, has demonstrated as to how this could be translated into action benefiting both the women and the community.

## iii) Experiences of India Population Project and Population Education Project

The school children are used as the channel of communication. It has been tried in some of the population education project and IPP. Under this, attractively produced folders or leaflets on Mother and Child Health are distributed. The teachers have explained the contents to the children prior to this. The children will act as channels of communication in home and in the community. With illiterate parents, the children going to school will have better influence and credibility and the new ideas and practices brought by them would be more acceptable.

## CONCLUSION

Communication has attained great importance in Health promotion and development of women and children. It is a link between the Health providers and community. Communication is a meansto mobilizing people and seeking their willing co-operation in political, social, health and Economic develop-



ment. The main role of communication is providing information, persuasion, rewarding and influencing the behaviour of the people. For effective communication an appropriate method and media are to be used effectively.

Media make communication situation, more effective. It helps to gain knowledge, understanding procedures, create interest, social support, evoke emotional response, and to stimulate action.

Mass communication and interpersonal communication have their individual and complementary roles. For success of any Health and Family Planning Programmes Mass Communication should be followed by interpersonal communication. So that awareness can be converted into action without any lapse of time. Media and Health are partners to progress but media cannot replace the workers. Use of modern media is more compared to traditional media.

In promoting people's involvement, communication and media are the link between the Health providers and community. Community participation is the corner stone for communication. Various experiences show that the demand and use of health services is much better when the people are involved, appropriately and adequately.

“If a man is educated only one is educated  
But if a woman is educated, the entire  
family is educated”

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### **Breastfeeding, Amenorrhea, and Postpartum Absinence**

For several months after childbirth full breastfeeding provides protection from pregnancy through hormonal suppression of ovulation, which is reflected in lactational amenorrhea. Full breastfeeding also plays a key role in promoting child health and survival. In some societies as a matter of custom, many women also practice sexual abstinence for long periods after giving birth.

Full breastfeeding has been defined as including both "exclusive' breastfeeding—that is, without giving any solid foods or other liquids to the infant-and "almost exclusive" breastfeeding—that is, infrequently supplementing breastfeeding with water, juices, or vitamins. With any supplementation, however, children faces the risk of diseases from contaminated water and utensils. The duration of postpartum amenorrhea—a rough proxy for the period following childbirth during which a woman does not ovulate—of course tends to be longer where the duration of breastfeeding is longer and full breastfeeding is more common.

## 2

# HEALTH AND MEDIA PARTNERS IN PROGRESS

*T.K. Parthasarathy*

The theme of the 3rd SEARB Regional Conference is "Peoples' involvement in the health and development of women and children". In other words how to make the public take interest in the programme and further its implementation.

Earlier speakers have discussed the sub-themes as stated in the Conference Bulletin.

In this short discussion paper, I propose to place my experiences with the media. As a journalist during the formative years of my career, I had developed some interest in development journalism, though the term "development journalism" has not come into general use. Some journalist evinced keen interest in this and were writing development stories such as innovative agriculture practices etc.

After joining the leaders and giants of health education, naturally communication for development got the upper hand and I was "in 14".

It has been said time and again (not yet ceased) that communication has an important role to play in development, particularly in health education, in dissemination of health information etc. Health educators have gone on record in selecting the mass media approach to be followed by group approach and individual approach as it will be impossible to have the message spread through face to face approach.

It is true that the spread of messages through mass media is fast, can reach a large audience, simultaneously. To quote an instance, Mahatma Gandhi's assassination reached the world over within a very short time after the journalist filed his first message "Gandhi assassinated" in New Delhi. Sardar Vallabhai Patel's death was in the wireless within 15 mts of filing at Bombay.

Media, mass media, can campaign, can advocate, can publicise. It is the speed that matters heavily. We understand the power of radio and the TV. It is useful to recall that in the early 1970s, agriculture broadcasts picked up popularity and the paddy cultivated came to be called "Radio Rice". The noted home science specialist, Dr. Rajammal, P. Davadas came to be known as

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“Pachakirai Ammal” due to her broadcasts on the value of Green Leafy Vegetables in the diet through Radio.

But the main stress in this presentation will be on print media. It was in 1966 at the first meeting of the health council held in Bangalore, certain officials (including seniors) complained that the mass media do not give adequate publicity to health programmes. Over two hours were spent on accusation and counter accusation. The then Chief Secretary of Karnataka Government, who Chaired the meeting, came down on the controversy. (I am quoting from memory).

He said: Media persons (including the Press Information Bureau and the State Publicity Department) have their own responsibilities as such and many of them have complained that health personnel do not answer their requests. Health people have said that media do not cover health functions.

“Why don’t the health personnel go half way and meet the media men. Naturally, the media would like to come and offer help; and this can be good get together to do a meaningful programmes. That opened the eyes of the complaining officials.

This “proverbial controversy” came up at a workshop in 1990 in New Delhi. The National Society for the Prevention of Blindness organised a three-day orientation workshop for senior media persons on eye health care. The constant complaint that the media blows up small failures but never cover “important success” was reiterated. After much of discussion it was decided by health/media persons to set up Health Media Center - India which will bring both media and health/media on the same platform and help each other. This Center, now a Registered Body, has so far organised four orientation symposia on HFA, AIDS, Tuberculosis, Smoking, Diabetes, Malaria etc. Medical/Health experts and media had good exchange of views without rancour.

We have to work with the media in a sustained manner. There are many ways we can involve the media - the print media in particular - Through Press Conferences, meetings with experts, programme managers in the field. The clients in the rural areas etc as to what they think of a programme, the difficulties etc. Success stories can be publicised. (Appendix A gives a diagramatic picture of what can be done. It is neither exhaustive nor rigid).

At the NSPB, we started programme of Advertisement on eye Health Care. We covered five subjects which gave short and attractive Ad copy on Glaucoma Cataracts, Mother’s do you know? Development of Children’s eyes, Squint, and Diabetes. These were sent to the print media with a request that those be published as display Ad on any convenient day. **The Hindu**, Madras covered all the Ads in one slot as a feature. The response from the medium and

small newspapers was very good but not from the national press. One leading daily published the Ads at a concessional rate. These Ads were picked up by many newspapers and magazines, **Social Welfare, Swasth Hind, Arogya Sandesh** etc.

The media also should realise its social responsibilities and cover health activities either as news items or health columns and features. Such trends are seen now. **The Indian Express** every Saturday carries one “Life Line”; **The Hindu** has health column on Sunday magazine, **the Pioneer** has a health page on alternate Saturdays. **The Times of India** has a health column on the back page on Fridays. There are many others working on these lines.

We should feed the press irrespective of whether they are used are not. We must work out a system by which this activity continues.

We should remember that media persons are also interested in the community health, welfare and development. The media “empowers” people with knowledge. Once armed with knowledge, the people are motivated to take actions.

Health and Media are partners in development, whether it is health, agriculture-ultimately the **people** are the masters.

What the media can do	What the health worker can and should do	Remarks
1. Coverage of functions Report appropriately	Health worker should become a facilitator - Send advance information Invitation Background Information Handout at the end of function	
2. Features for the media	Supply of sufficient information Available answers to any questions Supply additional material, if needed.	
3. Interview with dignitaries/ experts on health/FW	Sound the media on possible interview of experts - either exclusive/general (This should be handled with great care) Arrange time and venue Supply details about the expert (CV)	

What the media can do	What the health worker can and should do	Remarks
4. Press Conferences	Have informal discussion with the media about the programme Arrange for time and venue - Lunch or Tea Introduce the speaker(s) and subject matter Moderate by ground rules Issue a handout at the end of the Press Conference (Caution-Invite all including those who are diehard critics)	
5. Health columns (Weekly/fort-nightly/monthly)	Meet columnist periodically Provide needed information.	
6. Magazine sections of newspapers	Provide information in advance material for different groups Plan in advance Occasions - FW Fortnight, antileprosy day, WH day etc. Immunization date/week	
7. Newspaper supplement	Plan with newspaper provide articles, features Help get advertisement support Three months in advance planning	

General: Similarly the health worker can plan with magazines targetted for women, children youth etc. It is useful to meet the media informally once a month. Also have media persons on your campaign committees so that their experience can be used in planning programme. Remember media persons are equally interested with the development and welfare of the community.

EPI now reaches about 80% of children in developing countries and averts an estimated 3.2 million deaths a year. It had reduced the disease burden too, among children under age of five.

*WOR - 1993*





## *Section 4*

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*Training, Evaluation,  
Research*

# **1 THE INVOLVEMENT OF PEOPLE IN INTERSECTORAL COORDINATION FOR HEALTH AND DEVELOPMENT OF WOMEN AND CHILDREN IN INDIA**

*Dr. S.N. Hassan*

## **INTRODUCTION**

It is now widely recognised that substantial improvement in the health status of population can only be allowed through the combined impact of a wide range of social and economic development. Health is not the responsibility of the health sector alone and that collaboration of other social and economic sectors is vital for its success. The experience of the industrialized countries has shown that major causes of sickness and death-poor sanitation, illiteracy and low level of income-were effectively controlled well before the discovery of antibiotics. Diarrhoeal disease, and a wide range of other communicable diseases were controlled as a result of improvement in housing, environmental sanitation, high level of education, better nutrition following rising income and living standard. These positive developments in health care were therefore the result of inter-sectoral efforts.

As health is achieved by the people themselves, a well informed, well motivated and actively participating community is a key element to attain the goal. It requires the coordinated action of other sectors. Six important groups of active participants can be identified; the people high level policy and decision makers, the health professionals, health related sectors voluntary agencies and international organisations.

## **2. THE HEALTH AND DEVELOPMENT STATUS OF WOMEN AND CHILDREN**

For decades development has focussed primarily on the men who run government and hold bureaucratic power. AID agencies while exploiting women's labour, designed the project for men's benefits making the women

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invisible. In many developing countries, women are not legally entitled to own property and cannot get credit from banks unless their husbands co-sign.

Economic independence alone will not solve the myriad problems facing women in the developing world. Discriminatory attitudes are deeply entrenched and in most countries, boys are still valued much more highly than girls. In Bombay, out of 8000 abortions performed after parents learnt the fetus's sex through amniocentesis only one would have been boy. Throughout the developing world, more boys than girls are immunized, and girls who are brought to hospitals are generally in worse conditions than boys. Enrollment rates are considerably lower for girls than for boys in primary schools; the gap widens as they get elder.

Women who challenge the system face many risks. Those who get involved in grass root projects often trigger resentment among men. In Nepal some men have forcibly tried to prevent women from attending bank meetings or savings their even money, some men are so intolerant that they break open their wives piggy banks and spend their savings on drinks. In Islamic countries, fundamentalist object to women gaining power on religious ground. In extreme cases, women's community involvement can be dangerous, even deadly.

In many parts of India, girls are unwanted even before they are born. The birth of a boy is a cause for celebration while that of a girl is accompanied by the depressing spectre of huge expenses related to her marriage and dowry. In Telugu, there is a saying "Bringing up a daughter is like watering a plant in another's court-yard."

In our newspapers not a single day passes, without some atrocity on women seem to have become a daily occurrence, so much so that many of us have developed a selective memory loss and we have come to live with the growing criminalisation and violence in our society.

The organized sector accounts for approximately 10% of the total Female labour force whereas the unorganized sector accounts for approximately 90% of the female labour force. Due to this, they have many constraints in the professional growth-there is a lack of organization and backing from trade unions causing hurdles to achieve something substantial for growth and development.

### **3. STEPS TOWARDS CHANGE IN REPRODUCTIVE HEALTH OF WOMEN**

But women are fast learning how to best use their limited resources and influence to affect change. When they join forces, they have been remarkably

successful in combating social problems such as, illiteracy, over population and malnutrition. The reproductive revolution that started recently, is spreading fast across much of the developing world. The findings from the Demographic and health survey and family planning surveys on the nationally representative samples of more than 300,000 women of reproductive age in 44 developing countries since 1984 show that fertility has declined so rapidly that the trend has been called extraordinary “reflecting” fundamental changes in reproductive attitudes and behaviour. The study shows the transition from high to lower fertility typically begins with high status women who are educated and who live in the cities. In these countries, a rise in age at marriage has played an important role in fertility decline. The study also shows that the mother’s level of education itself has a substantial direct impact and is perhaps the most important of all social and economic influences on child mortality.

#### **4. CHANGING TRENDS TO INVOLVE PEOPLE FOR HEALTH AND DEVELOPMENT OF WOMEN AND CHILDREN IN INDIA.**

##### **Peoples Involvement**

Accelerating the process of development through active participation of the people at the grass root levels was the first step in launching the community development program in India in 1952. Development was conceived as an outcome of integrated approach and inter-sectoral coordination.

The significance of decentralisation in accelerating the process of development was emphasized by the Balwantrai Mehta Committee in 1957 which gave recommendations on new structure to involve local people in the development process, their powers and resources. The Committee recommended the establishment of an inter connected three tier organizational structure of democratic decentralisation at the village, block and district levels. The interest and support for Panchayat Raj did n’t last long due to various political reasons. It resulted in a status quo for many years.

The recent constitution 73rd Amendment Act, 1992 revitalises the process of people’s involvement. It envisages states to establish a three tier system of strong, viable and responsive panchayats at village, intermediate and district levels. States are expected to devolve adequate powers, responsibilities and finances upon these bodies so as to enable them to plan for economic development and social justice.

##### **Women’s Development**

The Act provides for reservation of atleast one third of the total seats for women at all levels of panchayat. These seats will be allotted by rotation to



different constituencies in a panchayat. The Act also provides that not less than one third of the total number of officers of Chairperson in the panchayat at each level shall be reserved for women. However, the objective of the Act cannot be achieved unless the rural women are empowered with necessary skills. The research studies show that women elected members lagged behind men in educational level in both zilla parishad and Mandal Panchayats.

Equally important is the issue of representation of women on various standing committees. The fact that actual business of the panchayat bodies is transacted through standing committees, their representation in adequate number of these bodies will have to be ensured. Since the Act doesn't have the provision on this account, the state legislation need to take cognisance of this issue. Further equal importance should be given for education of women.

Health and development of women and children is the outcome of the intersectoral co-ordination of various departments like education, nutrition, awareness, employment etc. Under the Act some of the subjects will be transferred to the Panchayat Raj bodies. At present, women's development is seen as compartments by various departments, there is hardly any convergence of the programmes. There is a need to strengthen co-ordination at various levels. The women and children development may be seen in totality by creating a separate standing committee. The role of people's involvement through peripheral institution will be very crucial in planning for women and children development.

It is suggested that Standing Committee on education should have at least 30 percent women as members. This may help in two ways. Firstly, it may ensure that the programmes of educational development undertaken by these bodies do not neglect women and secondly, presence of women on these committees, will also induce a process of change among other rural women. There should be provision for the orientation and training of these women elected members to perform their roles effectively in the sphere of health of development. Equally important is the orientation of other elected members on issues of women, child development and health as it has to be an effect of all concerned.

## **5. CONCLUSION**

The high level policy makers at the national and state level, the health related sectors, voluntary organizations and the peripheral institutions established by the elected members must become partners in the task of the health and development of women and children. The state must provide supervision and guidance, the health and development related departments must extend the



administrative and technical support the professional and voluntary organizations may provide insight and the local institutions (Panchayat Raj) will provide social mobilization to bring change in the behaviour. The ultimate success will depend how well these sectors will co-ordinate for the health and development of women and children in the country.

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“Research has shown clearly that mothers are pivotal to the integrity of the family and the community as economic as well as social units. In the first place, their work secures the health and well-being of the family; in the second place, their economic contribution in food production and distribution, other unpaid work, and also wage labour — although it has never been adequately quantified — provides the bedrock on which the community is built and can develop. High rates of maternal mortality therefore strike at the heart of the development process.”

## **Maternal Education and child Survival**

Surveys consistently report that mortality rates are lower among the children of more educated mothers.

To a large extent these education-related differences in mortality rates reflect differences in family living standards, access to health care, and similar influences. But recent studies have suggested that the mother's level of education itself has a substantial direct impact and is perhaps the most important of all social and economic influences on child mortality.

# 2 PARTICIPATORY RURAL APPRAISAL FOR SAFE MOTHERHOOD AND CHILD SURVIVAL

*\* Dr. S. Ponnuraj Dr. N. Narayanasamy*

**INTRODUCTION:** The Alma Ata Conference on Primary Health Care in 1978 emphasized the indispensable role of the community to implement Health care programme. Recognising this, quite a few countries have adopted and applied methods and techniques which could help in ensuring community participation in health programme. One such technique is **participatory Rural Appraisal (PRA)**.

**What and why of PRA:** PRA is both an attitude and methodology. It is “learning directly from the people, trying to understand their knowledge systems and elicit their technical knowledge”. PRA means reversals in learning. This implies roles quite different to those that outsiders (We) and villagers (they) are accustomed to play.

Under PRA method, we the outsiders

- \* establish rapport
- \* convene, catalyse, facilitate and
- \* enquire
- \* watch, listen and learn.

They, the villagers (community)

- \* map
- \* diagram
- \* quantify
- \* inform, explain
- \* analyse, plan, present

PRA thus is introducing new culture to many people. PRA facilitates active participation of the community. It enables the community to “own” and “use” the information for planning and excuting projects and programmes. It

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has developed techniques which have ensured participation of lay people particularly the rural poor as a means to initiate participation in the planning process and reinforcing confidence in order to become subjects and not objects of development programme.

**PRA and Health:** PRA as a technique of ensuring people's participation was first tried in planning and executing agricultural projects. Later the technique was extended to areas like social forestry, animal husbandary, irrigation, health and so on. The concept of PRA was introduced in health for two reasons. They are: i. prospectus of gaining information on health problems rapidly and cheaply; ii. direct focus on the participation of the community.

**PRA and Maternal And Child Health Programme:** The Maternal and child Health and Family Welfare Programme currently being implemented is also known as Safe Motherhood And Child Survival Programme. This is a centrally sponsored scheme / programme- a programme designed and funded by the centre. The programme is based on "blue print" approach for its rigidity and generally does not take into account the varying needs of the different social and demographic groups. It, therefore has failed to elicit the required participation from the community.

PRA with its focus on putting the people first in all developmental programme, would help in conducting the MCH & FW programme in a more meaningful way by involving the community at every stage. The Gandhigram with its vast experience of working "with" and "through" people made an attempt to apply the PRA technique in Safe Motherhood And Child Survival Programme in a village called Karattalaganpatti. We present here how did we go about the programme, the out come and the lessons we learnt.

**The Participants:** About 50 women in the reproductive age group both married and unmarried participated. The village health nurse of the village, the PRA team (2) of Gandhigram Rural Institute acted as facilitators, catalysts and observers.

**The Setting:** The PRA team members explained the purpose and objectives of the meeting. Then the entire gathering was divided into two groups- one group took up the task of analysing health problems of women while the other group discussed the health problems of the children in the community.

**The Techniques:** The techniques and methods adopted to elicit information on MCH & FW programme include:

- \* Focus Group Discussion - to understand womens' perception of Maternal Health Problems
- \* Mapping -to identify clients



- \* Eco Map - eligible couple mapping.
- \* Verbal Autopsies - to establish elation between health problem and resource

**The process:** Each group had a facilitator, observer and a presenter. The task of the facilitator was to facilitate the smooth conduct of the group work and to catalyse the group to the theme. The work of the observer was to see that the PRA exercises were conducted in accordance with the techniques and principles of PRA and to record the deliberations of the meetings.

Each group acted seperately. The First group preferred to sit under a tree in the village whereas the second group sat on the floor of the school building.

**The Results:** The first group which discussed the maternal health problems preferred to depict the facts and figures through a map. (Fig 1,2). The information depicted in the map include number of women of reproductive age group, mothers with infants, with children between 1 to 5 years, pregnant women, adopters and non adopters of family planning methods and women with anaemia. It was surprised to see that women discussed all matters connected with MCH & FW freely and frankly. After the map was drawn, the facilitator instigated the discussion to identify the problems and match the resources of health care to their problems. There was lot of discussion, arguments and debate before arriving at definite conclusion. No body felt monotonous. Every participant took active interest in the exercise and the excersise was quite lively.

The technique followed in the second group was focus group discussion/ interview. The exercise went on well. Village women were allowed to talk freely. The data gathered are shared among the participants of the group one is presented in Exhibit I

**TABLE I**

<b>DETAILS OF INFORMATIONS GIVEN BY THE GROUP I</b>	
Informations / Details	Number
Pregnant Women	6
Women who have undergone sterilisation	36
Mothers with infants	12
Women having severe Anaemia	02
Families with Four Children	16
Families with one Child (other than Infants)	12
Couples without children for the last 5 years	2
Households	134
Population	645

There is a health subcentre in the village but the centre has not been used for the last 5 years for want of village Health Nurse. Critically ill Cases” are generally referred to Government Hospital Dindigal, St Joseph Hospital (private) Dindigal, Primary Health Centre, Narasingapuram and Gandhigram Hospital. They are at a distance of 10 Kms, 8 Kms, 2 Kms respectively. (Fig.3)

Information elicited by the participants of group II about childrens’ health is presented in Table II.

## II DETAILS OF INFORMATIONS GIVEN BY THE GROUP II (Children’ Health)

Common Diseases	:	Cold, Diarrhoea, Measles, Worms, Fever with fits, Running ears
Infant Death	:	Two- Male=1., Female 1 Male died due to fits within 4 days: Female died within 15 days due to low birth weight
Polio	:	one female child 7 years old

## TABLE III

### DETAILS OF PRACTICES / METHODS ADOPTED BY MOTHERS TO PREVENT MORBIDTY AMONG CHILDREN

Immunization
Taking good diet 3 times daily during pregnancy
Sugar Salt Solutions for diarrhoea
Good weaning food from 8th month onwards
Breast Feedings
Taking bath regularly
Referring cases to hospital
Taking native medicine for worm infestation

## IMMEDIATE SOLUTION

Both the groups clearly indicated health care resources and the physical distance between the resources and the community. The participants wanted the VHN to stay in the Health subcentre so that they could utilise her service round the clock. They also demanded that two severely anaemic cases identified by them should be sent to referral centres. The VHN told the participants about the condition of the HSC and her condition to stay in. As for the second demand, the VHN replied that she would refer the case either to Gandhigram Hospital

or to the Government Head Quarters Hospital. The participants assured the VHN that they would take care of the repair work of HSC and arrange blood donors from their village, if necessary, to treat the highly anaemic women.

## **FOLLOW UP**

As assured in the meeting, the women met the officials of the Public Works Department and Electricity Board to repair and electrify the building. It was not easy task. The women had to write second time to the officials and finally the women were able to achieve their goal. The VHN was very happy to see the HSC in good condition and she readily moved into the HSC with her family and even conducted a delivery in the HSC! (After 4 Years).

The highly anaemic women identified were referred to Gandhigram Hospital and after blood trasfusion arranged by the village women their haemoglobin level were raised.

## **CONCLUSION**

Our limited experiance of application of **PRA IN SAFE MOTHERHOOD AND CHILD SURVIVAL (MCH & FWP)** conclusively proved that:

- i. PRA technique can be used to know the maternal and child health problems in the village
- ii. Women in the village do actively participate in finding solutions to the problems.
- iii. Involving of health workers in such exercises do help community to plan, identify resources and find alternative to the problems.
- iv. Women by themselves are able to develop their appreciation of their needs, involvement in **SAFEMOTHERHOOD AND CHILD SURVIVAL PROGRAMME**.

## **REFERENCES:**

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2. Chamber R 1990 PRA For Health & Nutrition Paper for Silver Jublee celebrations of Nutrition Society of India, At Staff College of India, Hydrabad.
3. RRA Notes 16 July 1992 IIED, Sustainable Agriculture Programme, United Kingdom.
4. World Health Statistics Quarterly, 1991, Vol 44 No 3 Geneva WHO.





MAP SHOWING THE DEMOGRAPHIC PARTICULARS



## REFERRAL CENTRES

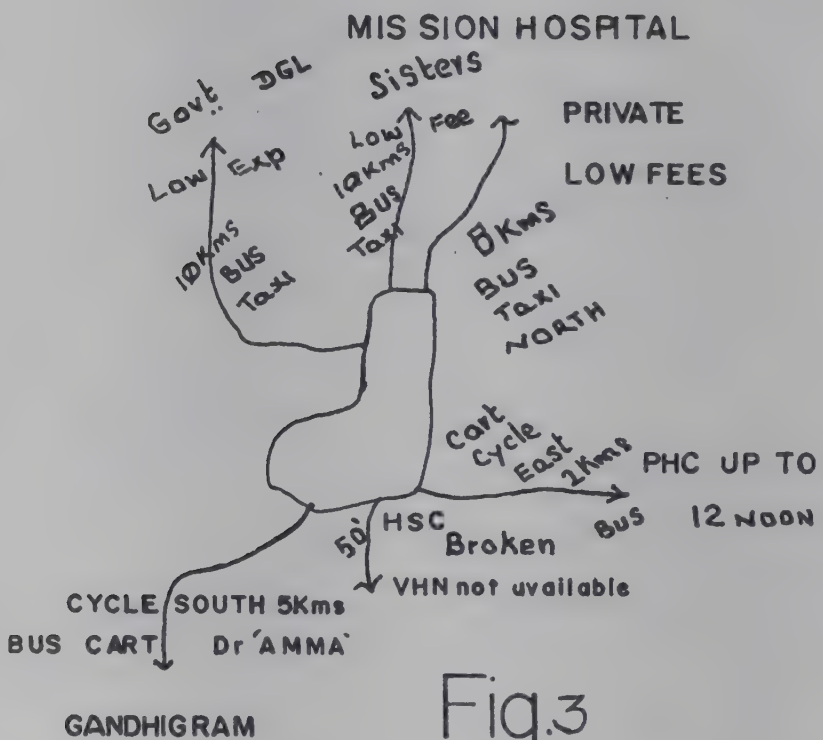


Fig.3



# **3 “PEOPLE’S INVOLVEMENT IN PLANNING, IMPLEMENTING AND EVALUATING PROGRAMMES FOR HEALTH AND DEVELOPMENT OF WOMEN AND CHILDREN WITH SPECIAL REFERENCE TO MATERNAL AND CHILD HEALTH AND FAMILY PLANNING - ORGANISATIONAL AND MANAGEMENT ISSUES”**

*Dr. M.V. Bapiraju Sharma, Ph.D. (Osm)*

## **1. INTRODUCTION**

The issues relating to women and children can no more be considered as low priority areas as they constitute more than 60 per cent of the total population of the country. They are the centre of development. Many countries have realised the significance and importance of women’s role in the socio-economic development of the nation, though belated.

The women’s issues are multi-dimensional, multifaceted and it requires multidisciplinary approach and total involvement of the people in every facet of the health care service delivery system. Women play a central and often a crucial role in family life, and in population and development activities.

There are five different issues which, directly or indirectly, relate to the status of women viz., political recognition, legal recognition, access to education, access to employment and improving health, to cite a few.

This paper will focus on certain dimensions which have mainly population and health related implications.

## **2. Issues relating to women**

The general issues relating to women/mankind deserve mention here before specifics are discussed. These are (a) high female illiteracy, (b) high

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fertility (large family size), (c) female foeticide, (a) female infanticide, (e) child marriages, (f) gender bias, (g) gender inequality, (h) Sexual abuse, (i) drudgery and physical violence, (j) discrimination in payment of wages, (k) Sati, (1) Dowry (m) Lack of health care facilities and under utilisation of the existing facilities. The other issues include terms for marriage-selection of mate, marriage patterns, forms, family formation, divorce, child custody, rights within and out side marriage, women's access to contraception and abortion, other reproductive rights, law of inheritance-property rights, structural inequalities. All these issues have a bearing on the health and development of women. The solutions to these problems cannot be worked out without the active involvement and participation of the people at various levels.

In respect of the status of women in the Social System, Epstein<sup>1</sup> has developed a model which postulates the relative status of women. The areas include (i) **Ideology and religion** men's image of women, women's self-image, education, socialisation, (ii) **Economic Setting** - Division of labour, family structure, demographic structures, (iii) **Political Organisation** mass media, kinship organisation, residential pattern, (iv) **Legal System** - marriage, divorce, remarriage and inheritance pattern.

Women need to be organised to 'empower' themselves. According to Gayfer,<sup>2</sup> the freedom to organise is the key to rural development in that otherwise poor rural women will not get their rightful share of the productive resources or participate in decisions that affect their lives.

Constitutional guarantees of equality, together with political rights, can be used as a lever to improve the status of women in areas where they are discriminated.

Since the commencement of the planning process in the country considerable progress has been achieved in the promotion of health of our people. In spite of such impressive progress, the demographic and health picture of the country still constitutes a cause for serious concern. There has admittedly been a relative neglect of human and social development. The neglect has been found to be in respect of women and children who constitute the vulnerable group.

The issues relating to women and children are inextricably interlinked and the women and child should be considered as one unit for purposes of rendering services in health care delivery system.

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1. Epstein, T.S. "Socio - Cultural and Attitudinal Factors Affecting the Status of Women in South Asia" ESCAP; Status of Women in Asia and the Pacific, Bangkok, 1989, p.42.
  2. Gayfer, M. Rural Development and women: Organisation is the Key Lesson from the Field. Convergence, Vol. xix, 1986, p. 20-24.

### 3. Government Policy

India is committed to attaining the goal of "Health For All by the Year 2000 A.D." The national health policy has been approved by parliament in 1982 and different goals have been set to achieve the goal of health. These goals could be broadly classified into (i) demographic goals (ii) family welfare goals (iii) Maternal and child health goals, and (iv) Immunisation goals. The set goals are to be achieved through primary health care approach which emphasises (i) community participation, (ii) inter-sectoral coordination and cooperation and (iii) use of appropriate technology.

Further, the attainment of this goal requires a thorough overhaul of the existing approaches to the education and training of medical and health personnel and the reorganisation of the health services infrastructure, providing for community involvement and involvement of voluntary organisations.

The policy also recognises need for integration of all plans for health and human development and specially more closely health related sectors, ensuring that the planning and implementation of the various health programmes through the organised involvement and participation of the community, adequately utilising the services being rendered by private voluntary organisations (PVOs) active in the health and family planning sector.

The population policy has also been approved as early in 1976 and the national health policy underscored the need for population stabilisation.

### 4. Health and Women

The health of a nation is a logical prerequisite to all economic development and social progress, because this greatly affects the quantity and quality of productivity and eventually the well being of the population.

Good health is the plank on which a women's ability to work, to give birth and to look after children, to attend to household work and to participate in many other domestic, agricultural and community work rests.

Poor health of mothers can be perpetuated from mother to child involving a vicious cycle of social, economic, cultural and biological factors.

Winikoff<sup>1</sup> has illustrated the interplay of the intergenerational perpetuation of ill health for women and girls in many poor societies.

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1. Winikoff, B. "Women's health in the Developing Countries" in Wallace, H.M. and Gird, K. Health care of women and children in Developing Countries". Third party publishing Company, California, 1990, p.168.



It was found that women of child bearing age in the developing world do not eat the recommended minimum of 2250 calories a day, according to Nafis Sadisk.

Female literacy and under five mortality have close relationship. Low female literacy and high under five mortality rate is observed in many developing countries including India.

In May 1991, the World Health Assembly adopted a resolution on "Women, Health and Development" calling upon the Director General to intensify the advocacy role of WHO at the international level to ensure that health status and quality of life of women receive the required attention especially in economic force." Inspite of many efforts at the international and national levels, health is considered as an insidious unfelt need and no body recognises its importance unless it is lost. Can we do anything to change the value system both individually and collectively? Can we make it a priority item in the agenda of economic development?

## **5. Concepts of Participation and Involvement**

Now let us discuss the concept of participation. An important objective of the administration - people linkage is to mobilise and involve people in development tasks. People's participation has to be viewed from the angle of participation in the formulation and implementation of strategic decisions which have an important bearing on the structure and functions of the socio-economic system.

By helping people realise their own potential, participation can accelerate the process of liberating their arrested energies and making them responsible actors in the drama of socio-economic change. A participative environment would create feeling of responsibility among the people. Let us address ourselves to see whether we have participative environment to create feelings of responsibility among the people? Do we encourage our subordinate staff to enable people unfold their potential? Let us also look at the question of who are the people.

Chaturvedi, rightly remarks that people is not monolith. It is fragmented. And therefore, it appears to be an operational necessity to identify those components of the community to whom particular development programmes are directed.

We always assume that there is an identity called "people"- large group of men with broadly identical objectives who are keen on achieving these objectives by broadly identical means. But 'people' as a whole in the form of

one entity cannot possibly become active partners in the decision making process.

Talking about participation and involvement, 'involvement' may be a more appropriate term and a more acceptable concept than 'participation'. While 'participation' implies sharing involvement connotes a sense of belongingness. Involvement may also satisfy the service propensity of the public.

## **6. Historical Recommendations**

It is appropriate, on this occasion, to recall and record the very valuable recommendations made by Bhore Committee (1946) and Mudaliar Committee (1959), the monumental documents in the health services sector. The Bhore Committee recommended that in each village a "Health Committee" consisting of 5-7 individuals should be established for procuring the active participation of the people in the local health programme.

Mudaliar committee, recommended that 'population planning' should be treated as a non-party matter and all political parties should include it in their programme as an essential major activity and that the promotion of family planning activity should be one of the duties of panchayats and panchayat samithies and family planning should be treated as an integral component of total health services. Both family planning and MCH services should be administered by a single officer.

During these last 3-4 decades many other committees have made recommendation on very specific or important issues. Unfortunately the successive governments at Central/State level did not take the findings seriously.

## **7. People's Involvement in Community Development - Case Studies**

Let us look at few examples of people's involvement in community development programme. Hyderabad slums (Andhra Pradesh) have earned an unique position in the whole country in promoting urban community development with people's participation and involvement in the programmes concerning them.

The humanistic attitude of the top officials and the development functionaries towards the slum dwellers have reduced the social distance and communication gap and enhanced the working relationship between the providers and the beneficiaries.

Dr. Vasudeva Rao<sup>1</sup> of the Council for Social Development (CSD), Hyderabad, in a study entitled "Impact assessment in selected slums of Hyderabad slum improvement programme III" has come out with his findings that the new concept of "Neighbourhood Committee" is slowly taking deep roots in the various stages of the project formulation, implementation and monitoring.

His study, though short, intended to give a feed back in respect of people's participation and involvement and to assess how far people are competent to shoulder responsibility (ies) to continue the programme in future, after the completion of ODA funding. Involvement of the local communities, local leaders, neighbourhood committee as a strategy has yielded better dividends in terms of sustaining the people's interest in development programmes for the slum dwellers.

The genuine interest of the providers of service to work with people is visible in this study. Combined efforts, partnership of the implementing agencies, local voluntary organisations and neighbourhood committees have been acknowledged as important approaches in the strategy. The need for bringing better management skills seems to be essential for the improvement of the programme inputs as indicated in the study.

According to Rameswara Sarma, many programmes in public health have faced a set back as a result of lack of people's cooperation. The example he cited include Malaria and Trachoma control programmes in our country.

Prof. Rameswara Sarma in his article entitled 'people's participation in health' has attributed lack of people's participation as the main reason for the inadequate success in the family planning programme in India. He mentioned that identifying community felt needs and promoting involvement of community organisations, prioritizing the felt needs and working with people would pave way for the solid and substantial involvement of the people in all the phases of the programme. The best example cited by him is Jamkhed in Maharashtra.

Dr. Kanandikar,<sup>2</sup> in his book, "People's participation in family planning" observed that participation of people is vital in the family planning programme without which it has little prospect of success.

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1. Dr. D. Vasudeva Rao, C.S.D. (1992) "Impact Assessment Study in selected slums of HSIP III." Municipal Corporation of Hyderabad (ODA project). Arunodaya Printers House, Hyderabad - 20.
  2. Pai Kanadikar, V.A. Director, Centre for Policy Research, Jaipur (People's Participation in Family Planning), Uppal Publishing House, New Delhi, (1987).



His study is based on an examination of four voluntary agencies actively engaged in the field of health and family welfare. These agencies are: (i) New Delhi Family Planning Association (ii) Gandhigram Institute of Rural Health and Family Welfare Trust (iii) VADU, Rural Health Project, Maharashtra (IV) Comprehensive Rural Health Project, Jamkhed (Maharashtra).

In addition to the above, the author has studied the implementation of family planning through panchayat in two states of Madhya Pradesh and Gujarat. In this model, the results are mixed. The study explored the institutional, formal and informal structure and process of participation in family planning programme. It has also compared the efficacy and brings home the problems of participation and how it can be tackled successfully in the diverse settings of the country. the study has made a number of recommendations on the subject.

The participation in family planning, as defined by the author, is a process whereby the consciousness of 'Small Family Norm' is spread with the help of enlightened citizens, voluntary associations and each of the acceptors, ultimately leading to voluntary acceptance of the 'Small Family Norm'. This requires building specific institutional channels for providing the means for such participation.

There are many common areas of approach adopted by these voluntary organisations namely (a) integrated approach (b) identification of local leaders and working with them after orienting them (c) microlevel planning (d) felt needs approach (e) coordination (f) utilisation of local organisations like mahila mandals, youth forums etc.

Communication gap between the researches and field operations seems to be one of the major weaknesses in the system. Planners should bridge the gap.

The working group on population policy of the Planning Commission of India (1980) in its report opined that the task of bringing down fertility rate in the country will not be easy to achieve unless the programme of family planning had the fullest participation of the people, individually and through their representative institutions, voluntary associations, local organisations etc.

The issues relating to people's involvement have to be seen from different dimensions and it requires holistic approach. What should be emphasised is not a dichotomy between participation and involvement, but an ideal synthesis of these two: genuine participation must incorporate the basic tenets of involvement.

## 8. Family Planning and Literacy

‘Literacy’ is one of the most important dimensions which influences people’s participation and involvement. Well informed public and citizenry are always an asset and their contribution would be positive.

It is observed that one of the major set back in the Indian context is the illiteracy among women. According to 1991 census there are about 202 million illiterate women in the country (age group and 7 and above). Women constitute nearly 61 percent of the total illiterate population. There are 70 districts in India having female literacy rate below 20 percent. There are 90 districts having birth rate more than 30 per thousand population. Low literacy and high fertility phenomenon is operating in these population groups. Prevalence of wide spread illiteracy among women especially in the rural areas and urban slums has been causing serious concern to all those engaged in planning and development. There is very close correlation between literacy and fertility.

The National Literacy Mission<sup>1</sup> (NLM) has come into being, with an objective to impart functional literacy to eighty million illiterates in 15-35 age group by 1995. Most of these illiterates would be target / eligible couple under family planning programme.

“Education” according to Nafis Sadik<sup>2</sup> is perhaps the strongest variable affecting the status of women. An educated woman will:

- likely to delay her marriage and postpone child bearing.
- use contraception more frequently and select the most efficient method.
- use health services more frequently and usually less vulnerable to the risks of child birth.
- likely to have better communications (inter spouse communication) better relationships and have more involvement in making decisions at the family level especially the size of the family/number of children.
- have more chances for employment and gains confidence which enables her to participate in community activities.

According to world population report “A mother’s education is the single most important factor in keeping her family small and her children alive”. With an education, the women’s status steps beyond the confines of motherhood. Further, the quality of life in the family of an educated women becomes a priority”.

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1. National Literacy Mission (1978), Government of India.

2. Sadik, N. Women : the focus of the nineties. Populi Vol. 16(2) 19,1989.

According to UNESCO<sup>1</sup> many studies have shown that employment of women appears to exercise a marked influence on family size and fertility. Employment of women contributes to reduction of family size and fertility through the following :

- working women marry at a later age.
- when women work in the non-traditional and non-agricultural sectors.

“Literacy is the only way to defuse India’s population Bomb” has been stressed in a recent meeting of the parliamentarians on population and development. (June’93, New Delhi).

## **9. Recent outlook of Government**

Democratic functioning will alone give long lasting results and will ensure greater involvement of the people in addressing issues and problems facing them irrespective of its dimension. The approach requires patience and perseverance and the providers of service must not forget this fact. In all its essence it is an educational approach.

At this juncture it is worth while to know the efforts put forth by the Central Government to involve people. The constitution of India has made detailed provisions for ensuring protection of democracy from parliament to panchayat.

The approaches and strategies adopted during 1976 to achieve targets under family planning by over enthusiastic/ over zealous departmental personnel, beauracrats, officials and some sections of politicians have left long lasting scars in the memory of people affected. That has costed the then government, its throne. This is all the more the reason for the implementors to get in touch with the people and develop suitable programmes by involving them.

The recent 73 rd Amendment of the Indian Constitution is an important landmark making people’s participation in rural development, a statutory one. It is an epoch making event in the history of democratic decentralisation. It is designed to ensure the participation of the poorest of the poor in the process of socio-economic development of which health is an integral component and no section of the society should have a feeling of being left out.

The main objective of enacting this constitution Amendment Act is to improve the participation of the people in the process of their development.

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1. UNESCO PROAP “Women, population and development: Abstract Bibliography Series No.11 Bangkok 1991, p. 80-81 (Population through education programme service).



We cannot have real development in the country unless panchayats are made responsible for the development in the villages and the people who live in the villages are involved in their own development. It is a revolution that will open the doors of opportunity to half the population of our country - the women of India.

The village panchayats are empowered to prepare and implement plans for economic development and social justice. Health and sanitation, primary health centres, family welfare, women and child development education are all included in the eleventh schedule.

Another significant land mark in the process of people's involvement is the Nagarpalika Act approved by the parliament - constitution 74th Amendment Act 1992. This is a step in the process of devolution of powers to the people at the grassroot urban areas level.

In these Acts provisions have been made for the constitution of a "District Level Planning Committee" with a view to consolidate the plans prepared by the panchayat and municipalities and prepare a development plan for the district as a whole. It is mandatory for the State Government to constitute a district planning committee in every district.

Similarly 'Metropolitan Planning Committees' have also to be constituted for the metropolitan areas. The powers and functions have been categorically spelt out.

The Prime Minister of India, Sri P.V. Narasimha Rao addressed a letter on May 5, 1993 to all the sarpanchas (Head of village panchayats) in the country, that the village panchayats would soon become vibrant institutions performing necessary developmental, regulatory and general administrative functions.

The need of the hour is that the medical and health bureaucracy, which is a highly professional and technical unit has to reorient its value systems and learn to work with local/peripheral people's institutions. Organisationally and managerially large scale adaptation is envisaged to accomplish the desired objectives. The question is - can the system orient itself to the changing needs with less incubation gestation period?

The world summit for children (1990) adopted a list of goals proposed to be achieved by the year 2000. (Annexure 1)

## **10. People's Involvement - A few questions to be answered**

When we intend to seek people's involvement one has to necessarily address himself with the following: who are these people? Why are they to be involved? when are they to be involved? By whom they are to be involved? How

they are to be involved? and where they are to be involved with reference to the proposal theme?

People are not monolithic. People are heterogeneous and gregarious in nature with diversified interests and varied objectives. The needs and demand for services differ with age and sex and place.

All of us are very much aware of the problems and issues concerning women, health and development, more specifically maternal and child health and family planning for over over many decades. In spite of such impressive progress, the demographic and health picture of the country still constitutes a cause for serious and urgent concern.

There are many non-government organisations but only few are functioning in the area of health and family welfare. It is essential to study their inputs and outputs to the extent of community participation. The people have the right and duty to participate individually and collectively in planning and implementation of their health care. (WHO 1978)

Many social policies have been formulated and many welfare measures have been introduced to improve the lot of women and children in general and in specific in respect of maternal and child health and family planning. Now it is termed as child survival and safe motherhood programme.

People could be broadly classified into three groups: (i) People's representatives at various levels from panchayat to parliament (ii) People's servants/providers of service (Employees paid from the resources of the State exchequer) (iii) people themselves (consumers, target audience, beneficiaries and non-beneficiaries) with positive and negative attitude and different value systems and orientations. Those who develop conflicting values, negative attitudes act as barriers to growth and development and hinder progress. (Annexure 2). Is people's participation an end in itself or a means to the achievement of certain specified objectives? How do we perceive it?

## **11. Organisational and Management Aspects**

Some of the issues which have a bearing on the organisational and management aspects are discussed below:

- The maternal and child health and family planning programme seem to be male dominated programme though in fact, the women have to take major responsibility for decision-making. The women should have the freedom to decide the size of the family, the timing of births etc. This should be recognised as a reproductive right of a woman, because biologically the woman is responsible for child bearing and child rearing as the woman is endowed with radiant motherhood.

Most of us have heard from several sources that family planning is a 'medical problem' while it is to be considered as a socio-economic and demographic problem which requires inter disciplinary approach and intervention. This could be considered as a 'perception problem'. People should be considered as a denominator for social and development activities.

There are many instance where the non-governments and government service units are functioning in the same areas which amounts duplication of scarce resources, and overlapping jurisdiction and many a time it becomes nobody's baby and accountability is lost.

The people are not mere numerical numbers. People are a body of persons linked by a common knowledge and common interests in given community.

For the organisations to come into being and to survive political endorsement is very essential. Allocation of resources is essentially a political decision based on social preference and only partially on economic rationale. This is to be remembered while planning exercise is being done.

People's Involvement, in real sense, aims at involving people in problems identification, prioritisation, programming, implementation and evaluation. This and the above would call for major structural changes in the organisation and management practices.

## HEALTH MANAGEMENT

Health Management embraces the whole process of planning, organising, directing, controlling, evaluating and coordinating resources for the development of health programmes aimed at improving the health status of the population as a whole, based on community participation and responsive to the needs of the people.

Health management/health administration is essentially a system a administrative roles, functions and tasks carried out by individuals at various levels of administration in order to improve the health of the people (WHO, 1977). Thus, it implies that management is to make efficient use of resources and to get people to work harmoniously together to achieve objectives. To achieve the above a) it is desirable to introduce management audit (self evaluation) in the health care delivery system right from top leadership. b) To strengthen the management and planning skills at all levels of service delivery system, c) To prepare manuals in planning and development in health care for different categories of functionaries from district to periphery. The management issues relate to health manpower planning (Human resource development and manage-



ment), materials management (logistics and supply management, financial management, transport, cold chain system, office, field operations and outreach services, institutional activities, health communications (IECM), MIES. Health care delivery system is considered to be labour intensive and man management is crucial.

The health managers should ensure proper documentation. Information support is needed for all planning and management activities. Participatory management is to be encouraged. Training should include management development, management practices essential to change the culture. The important management skills include (i) obtaining information ii) Information analysis iii) using information (planning iv) decision making v) monitoring and evaluation (vi) communicating and working in a team environment (vii) Training and developing personnel (health manpower), organising training programme, delegating authority and tasks (viii) financial management-budgeting etc.

The modern management techniques and methods have to be utilised to the best advantage of the health services. How to exploit them? This is the task before us.

Let us review how many of us have been able to develop proficiency in these areas. What should be done by us to be practitioners of management sciences in health services sector?

### **13. Organisational Issues**

Organisation is the way in which duties are assigned to individuals, tasks are structured, procedures are delineated, people are grouped into work units, and responsibilities and formal authority are assigned. These factors influence inputs of the personnel. It implies that 'organisation' is 'people'. People have feelings. Feelings are the chief determinants of human behaviour. What is our approach - personnel or product oriented?

Organisation is to arrange people into working groups, associating those with similar functions and purposes so as to get the desired result from their group actions. This is the concept of team approach. Do we have health teams? Do we believe in team formation, team approach, team concept and team functioning in public health and allied specialist areas?

Organisations must have imagination, initiation and innovation. They require community acceptance and support. All medical and health institutions are in a way community organisations and institutions.

Many steps have been taken by the Government of India and State Government for implementing and improving maternal and child health

services and family planning. Over the past, 3 to 4 decades, the infra-structure have undergone extensive changes and expansion in stages. The structure at the rural scenario is more solid and sub-stantial (subcentres and primary health centres) when compared to urban areas where there is no well defined structure. Revamping urban health services is still to take a better shape.

Introduction of Multipurpose Health workers scheme, village health guides scheme, converting vertical programmes into horizontal service programmes (except leprosy), establishment of upgraded primary health centres, subsidiary/community health centres, post-partum programme units, introduction of MIES, and cold chain system, training projects, providing additional equipment and transport facilities, restructure the jurisdiction of the institutions in the rural areas are to mention a few. In spite such impressive organisational inputs and structural changes, a doubt arises why we are not able to achieve the objectives? The reason is the obvious inadequate involvement of the people, the beneficiaries. There is a need for a policy review. Corrective measures are to be instituted to remove bottle-necks and modify strategies.

It is desirable to work out standards and norms for service inputs as well as out puts in order to emphasise qualitative services. There is need to consider introduction of 'quality control' and quality circles concept in health care delivery system also.

Organisations must have (i) systematic performance appraisal (ii) potential appraisal (iii) career development (iv) training (v) counselling and feed back (vi) organisational development. Unless these subsystems co-exist and build upon each other effective human resource development is unlikely to result in.

According to Peter Drucker, success and failure in any organisation could be traced to the quality of the people within the organisation. The successful administration rests on three basic skills namely, (i) technical skill (ii) human skill and (iii) conceptual skills. Top level management must have conceptual skills followed by human skills essential for the success of any programme.

Illiteracy, ignorance, superstitions act as barriers for favourable acceptance of services and many a time the people's participation and involvement will not be forthcoming and the programme inputs do not yield expected results. These situations have to be conquered by appropriate health education/information, education, communication and motivation strategies. Planned efforts are needed to neutralise the negative concepts, feelings and actions and gradually convert them to play positive roles. Planned, deliberate, intentional, sustained inputs and efforts are needed from the providers group to reduce negativity to neutralisation (de-education approach) and neutralisation to

positivity (re-education approach). This is possible when the providers groups are properly oriented and well trained in extension methodology and approach besides management aspects in respect of each programme. The focus shall be on "how to work with people". The people could be personnel within the service delivery system and those others in different communities.

In the recent past the urge for 'people's involvement' has been expressed both in political and non-political and scientific gatherings but very little seems to have been done to translate this 'will' into action. This is the crux of the problem, resulting in meagre performance in different fronts.

## 14. Planning

The importance of planning needs no emphasis. Centuries back, Tiruvalluvar, a famous tamil poet has stated that "the energy that is spent on action without being first adequately spent on planning it out, will be empty of results, what ever may be the manpower placed on the field." This statement of Tiruvalluvar, I hope, shall inspire us to the concept of development planning process. Macroplanning and Microplanning/locale planning are a must to improve the quality of services, for optimum utilisation of resources, for providing greater satisfaction to the consumers/citizens. The bottom up planning is to be encouraged. There is need for decentralisation and delegation.

Preparation of action plans with integrated approach for each primary health centre and sub-centre should be prepared for different programme by the providers of service together with the communities/potential beneficiaries. This should be a team endeavour. Similarly District Health Plans should be prepared following the procedures and guidelines available. Well documented plans are the blue prints for action i.e. implementation.

One has to remember that health needs change from community to community and time to time, due to the advancement of science and technology, industrialisation and urbanisation and population dynamics. These changes include the nature of diseases (acute communicable to chronic non-communicable) social and environmental conditions, medical care practice and organisation. All these changes influence planning process. The health planner should be cognisant of these factors.

**15. Involvement** will ensure better management of the programme as well as its sustenance and continuity. The beneficiaries become satisfied acceptors of the services. Some questions to be answered in this connection are What is the work culture in the health care delivery system in our country? How we view the consumer both for curative and preventive services? What are our perception levels? Did we learn how to work with different communities and



beneficiary groups? Are we ready to accept the concept of people's involvement in all the phases of planning, implementation and evaluation? How many of us are trained and oriented formally or informally in working with people? realise that inadequate/lack of involvement of the communities has resulted in low levels of utilisation of services? How many of us are able to identify ourselves with the community to reduce social distance? What is our attitude towards our colleagues either superiors or subordinates? Are we able to accept and accommodate ourselves when our colleagues/juniors put forth free and frank opinions during the process of formulating action plans? Do we encourage realistic feedback of what is happening in the health care delivery system? Do we have profiles of community diagnosis/situational analysis to plan Health Education/IECM activities? Are we familiar with the management tools and techniques in planning and implementation of different health service programmes? Do we encourage health team approach? What are our efforts to build health teams? I have no answers to most of these issues. The solutions are to be found collectively by the providers and community through group analysis.

The adhoc and fragmented approach should be discouraged and no scope should be given to the communities to doubt the bonafides and interests of the providers.

Winslow's definition of public Health (1920) underscores "Organised Community Effort".

## **16. Implementation**

Implementation is the responsibility of the peripheral units of the health care delivery system where there is direct contact between the consumers and providers. Medical officer is the head of the team of providers of service both curative and preventive. It is his job to implement action plans drawn by him alongwith his team after careful planing process in which phase the involvement of the people has been taken care of.

Non involvement of the potential beneficiaries and acceptors in most of the programmes is found to be the root cause for low levels of acceptance, apathy, supersition, lack of credibility on the part of implementors, false promises, lack of coordination among various implementing agencies. Duplication of efforts is often noticed wasting scarce resources. Overlapping of jurisdictions is often observed especially in urban areas.

We can prepare excellent 'plans' and 'action plans' with all the intellectual inputs but it is only after implementation the outputs could be seen.

In actual implementation process, the health manager is likely to be confronted with the following problems.

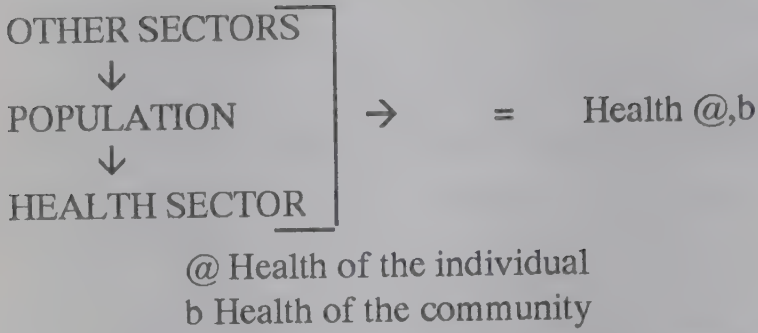
- i reluctance of doctors to work in rural areas.
- ii general deficiencies in staff, their service conditions and facilities.
- iii lack of chances for upward mobility, continuous guidance and training.
- iv poor quality of services, inadequate coverage.
- v insufficient attention to details.
- vi general weakness in infrastructure.
- vii weakness and ambivalence in people's participation.
- viii lack of cooperation from staff, threats of labour unions, staff associations, to mention a few.

The suggested strategy is that people's participation entails creation of opportunities that enable all members of the community and the larger society to actively contribute to and influence the development process and to share equitably in the fruits of development. This strategy requires decentralisation of planning implementation and evaluation of programme by people's own institutions like village panchayats and Health Committees etc. with statutory responsibilities. For this a responsible and efficient management is essential. Participatory management is to be encouraged.

At the grassroot level, for different activities, the following individuals and groups would lend a strong support and get involved. These are local/ community leaders (formal/informal), non-governmental organisations, voluntary organisations, Nehru Yuvak Kendras, Mahila mandals, youth clubs, cultural organisations, health committees. All are not interested to work in health and family welfare area directly. Hence there is need to identify their interests, start from where from the people are. This requires a little amount of preparatory work for each programme. It is desirable to take up SWOT analysis as indicated. The trained birth attendants and village health guides should be actively involved in the rural and tribal areas as the communities depend heavily on them. (Annexure 3)

As we are all aware, health is the result of the inter-action between the population, health sector and other sectors, represented in the following diagram.

## Diagram



One must always be conscious that it is difficult to measure needs and the demands can be assessed from the information media and through the people's representations to local administrators.

## 17. Evaluation

Now let us view the issues relating to evaluation of the programme with people's participation. Evaluation is to be an inbuilt component and it is closely linked to objectives formulated. This goes back to planning. What we have planned? What we intend to achieve with our resources?

We have accepted that people are now part both in planning and implementation process. In evaluation, we need measurable indicators to measure the provider's inputs, involvement in all phases.

Concurrent evaluation should be a part of programme planning and implementation process. It will help to take up mid-course corrections.

## 18. Issues relating to M.C.H. and Family Planning

The issues relating to maternal and child health could be broadly summarised as follows:

- reduction of maternal morbidity and mortality.
- reduction of infant morbidity and mortality.
- reduction in the proportion of low birth weight babies.
- reduction of under five mortality.
- creating demand generation to avail of the family planning services both spacing and terminal methods to increase the acceptance and adoption levels (Emphasis on spacing methods).
- to reduce illiteracy among women to mention a few salient issues.

(If any issue is repeated or reiterated it is to stress the importance of the same).

The intensity and magnitude of the problem is very high. The health sector alone cannot accomplish these tasks. The imperative need is people's



involvement. People's participation is the most important single factor for the success of these endeavours.

Let us once again examine what is people's participation? and what is not people's participation? What are its constraints and what are its dimensions? What are the prerequisites for effective people's participation? With all humility, I would submit that individually we may not have answers to all these questions. Group effort and collective thinking would give us rays of hope to discover possible and feasible alternatives to revolutionise the social values within the system and outside. Our main focus is to be on the "people" and their involvement and participation in primary health care approach to achieve the goals set for 2000 A.D. within 7 years? This is not far off? How to achieve? How to proceed? This requires collective wisdom and action.

We must work with such team spirit and dedication to work with people (catalyst role) so that they can discover their own needs, creating situations in which they can make decisions, set goals, plan, implement and evaluate, modify, contribute their labour and resources and equally share the fruits of their efforts.

All these issues require urgent attention. The National Health Policy document (1982) has accorded high priority to maternal and child health immunisation (items requiring urgent attention).

This being the policy, what is its reach and effectiveness in terms of micro-planning? what are the intervention mechanisms introduced into service delivery system? Even today, are we able to equip our peripheral units with necessary maternity kits, dais kits and diagnostic equipment, stationery, to improve quality of services and sustain the interest and involvement of the people? The need is to take up review of facilities and strengthen inputs for better results. A list of few service areas in M.C.H. & F.P. for people's involvement is provided. (Annexure 4)

## **19. Conclusion**

Since independence a great deal of development and expansion have taken place in the health services infrastructure in the country and various parameters of health have improved considerably. In spite of such impressive progress the demographic and health picture of the country still constitutes a cause for serious and urgent concern as mentioned.

The issues relating 'to maternal and child health and family planning' deserve to be given high priority as the women and children constitute more than 60 per cent of the total population. The morbidity and mortality are still very

high and there is urgent need to pool resources and efforts to reduce morbidity mortality and fertility levels. This could be accomplished only through the active involvement of the communities besides many others.

A few observations are made, suggestions are placed for consideration of the distinguished participants.

- Meaningful community involvement and participation are lacking. This requires improvement.
- Health needs are largely felt and identified by the providers group planners and administrators, rather than the people who are the consumers/beneficiaries and stake holders.
- Illiteracy among women is considered to be a major factor for under utilisation of health care services.
- The micro planning concept is yet to find a place in the health care delivery system to yield better results.
- There is more of adhocism in programme planning and implementation. Evaluation is not an inbuilt activity.
- Health Education - IECM requires appropriate reorientation and modification to seek more involvement of the people to sustain their interests in the programmes envisaged.
- There is need to have assessment committees to assess the involvement of the people and impact of the programmes and different components of service delivery system.
- The training and orientation of health manpower require to be restructured incorporating more of management and social science components for the enhancement of knowledge and skills - how to involve people, how to work with people in planning, implementing and evaluating different programmes designed. There is need for human relations approach.
- Literacy programmes designed for women should include the functional component of maternal and child health and family planning along with other value orientations in addition to small family norm.
- Literacy and upgrading the status of women are important determinants of fertility decline and hence the need for literacy programmes.
- The isolated and fragmented approach should be replaced by integrated approach with effective convergence of services.
- Village/local level health and family welfare committees shall have to be constituted comprising members of the panchayats, women

representatives, local leaders with statutory powers and delegations as an integral part of panchayat system.

- The tendency of utilising the professional level functionaries of Health Education/IEC and MIES as errand runners should be put an end to and they should be utilised appropriately.
- Research and Development wing has to be established (emphasis on social science research) in each state.
- Area specific approaches and strategies have to be evolved to work closely with the target populations.
- The people's participation at grass roots has still to be fully understood.
- There have been swings in approaches - reorganised programme with extension approach laid emphasis on people's participation. No scientific approach. Trail and error method has been the approach. This approach should give place to scientific planning and management.

In the foregoing paragraphs, I have made a humble attempt to the issues relating to planning, implementation and evaluation with specific reference to M.C.H. and Family planning and people's Involvement in the process. Inspite of the impressive progress in certain areas much is yet to be done to get a satisfactory output. This is only possible when there is intensive involvement of the poeple in all the above phases. This should be expeditiously planned and implemented and this conference may address itself to the task and discuss the various dimensions involved in the problem. It is appropriate to recall what Jatipita Gandhi once said that CUSTOMER IS THE MOST IMPORTANT PERSON IN OUR PREMISES... This approach is more appropriate and holds good even in the health care delivery system which needs no elaboration. As Aristotle said the END OBJECT OF MEDICINE IS HEALTH and medicine is a social science as expressed by many eminent medical and health experts from time to time. This should be recognised and respected.

It is unfortunate that these aspects have not been viewed in the correct perspective by the present day providers of service due to lack of orientation and value system. There is need to have an attitudinal change to view things in the right perspective. 'Health' is not a medical problem but it is influenced by social, economic conditions, political decisions and cultural factors in any given place and time, and convergence of services is a must for the effective involvement and accomplishment of desired objectives.

This underscores the need for inter and intra sectoral coordination at all levels. The health system within and without should function with heterogenous



groups (population) in all phases as expressed earlier. This reality is to be appreciated and adopted by the health planners and providers of service by reducing the social distance within the system and outside and **work with the people** rather than work for the people.

It is needless to reiterate that people's involvement is the corner stone for the success of any people's programme and more specifically maternal and child health (child survival, and safe motherhood programmes) and family planning in the health services system.

In conclusion I take this unique opportunity to profusely thank the organisers of this excellent conference for having given me a chance to present this key note paper for this scientific sessions.

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Studies in Family Planning Vol. 24 No.2 March/April, 1993. P.73-86

## **The year 2000: what can be achieved?**

The following is the full list of goals, to be attained by the year 2000 which were adopted by the World Summit for Children on 30 September 1990

### **Overall goals 1990-2000**

- \* A one-third reduction in under-five death rates (or a reduction to below 70 per 1,000 live births- whichever is lower).
- \* A halving of maternal mortality rates.
- \* A halving of severe and moderate malnutrition among the world's under-fives.
- \* Safe water and sanitation for all families
- \* Basic education for all children and completion for primary education by at least 80%.
- \* A halving of the adult illiteracy rate and the achievement of equal educational opportunity for males and females.
- \* Protection for the many millions of children in especially difficult circumstances and the acceptance and observance, in all countries, of the recently adopted Convention on the Rights of the Child. In particular, the 1990s should see rapidly growing acceptance of the idea of special protection for children in time of war.

### **Protection for girls and women**

- \* Family planning education and services to be made available to all couples to empower them to prevent unwanted pregnancies and births which are 'too many and too close' and to women who are 'too young or too old'. Such services should be adapted to each country's cultural, religious, and social traditions.
- \* All women to have access to prenatal care, a trained attendant during childbirth and referral facilities for high-risk pregnancies and obstetric emergencies.
- \* Universal recognition of the special health and nutritional needs of females during early childhood, adolescence, pregnancy, and lactation.

### **Nutrition**

- \* A reduction in the incidence of low birth weight (under 2.5 kg.) to less than 10%



- \* A one - third reduction in iron deficiency anaemia among women.
- \* Virtual elimination of vitamin A deficiency and iodine deficiency disorders.
- \* All families to know the importance of supporting women in the task of exclusive breastfeeding for the first four to six months of a child's life.
- \* Growth monitoring and promotion to be institutionalized in all countries.
- \* Dissemination of knowledge to enable all families to ensure household food security.

### **Child health**

- \* The eradication of polio.
- \* The elimination of neonatal tetanus (by 1995).
- \* A 90% reduction in measles cases and a 95% reduction in measles deaths, compared to preimmunization levels.
- \* Achievement and maintenance of at least 90% immunization coverage of one - year children and universal tetanus immunization for women in the child bearing years.
- \* A halving of child deaths caused by diarrhoea and 25% reduction in the incidence of diarrhoeal diseases.
- \* A one - third reduction in child deaths caused by acute respiratory infections.
- \* the elimination of guinea worm diseases.

### **Education**

- \* In addition to the expansion of primary school education and its equivalents, today's essential knowledge and life skills could be put at the disposal of all families by mobilizing today's vastly increased communications capacity.

## PEOPLE AND THEIR INVOLVEMENT IN HEALTH CARE SERVICE (M.CH. and Family Planning) - an approach chart

People	Planning	Implementing	Evaluating
(Beneficiaries) Clientele/Consumers Target Groups (Rural, Urban, Tribal)	<ul style="list-style-type: none"> <li>* Identification of felt needs</li> <li>* Involvement in prioritizing the needs</li> <li>* Preparation of action plans</li> <li>* Pressure groups</li> <li>* (- ve), + ve, O spread effect</li> <li>* Credibility in advocacy</li> <li>* Less resistance</li> </ul>	<ul style="list-style-type: none"> <li>* Share responsibility</li> <li>* Mid course correction (easy to modify)</li> <li>* Sustained involvement/approach</li> <li>* Less expensive approach</li> <li>* Less/No over head administrative charges</li> <li>* Greater involvement Quick/acceptance volunteers</li> <li>* Modifications can be suggested</li> <li>* Loopholes can be plugged</li> <li>* Unbaised approach</li> <li>* Easy to get cooperation</li> <li>* Committed Personnel</li> <li>* Greater involvement</li> <li>* Local problems can be solved with better identification.</li> </ul>	<ul style="list-style-type: none"> <li>* Can't find fault with outside agency</li> <li>* More Involvement if (Societal stigma) fails.</li> <li>* Improvement for next programme</li> <li>* Unbaised approach</li> <li>* Watch dog aspect</li> <li>* Can suggest better ways for next programme</li> <li>* Constructive criticism</li> <li>* More subjectivity</li> <li>* Less objectivity*</li> <li>* More Bias (generally this is not advisable as there will be bias/More subjectivity creeps in</li> </ul>
(Non - Beneficiaries) (all categories & groups) -ve groups/individuals +ve groups/individuals Neutral groups/individuals)			Achievement of desired objective Project success and substance.
Providers of service (Prog. Implementors)	<ul style="list-style-type: none"> <li>* Free and Frank opinions?</li> <li>* Smooth implementation.</li> <li>* Employee motivation and morale</li> <li>* Proper resource utilisation</li> <li>* Better management</li> <li>* Willingness to work with people (Target groups)</li> </ul>		
	<ul style="list-style-type: none"> <li>* People's can be broadly classified into three groups</li> <li>* People's representatives from Panchayat to parliament</li> <li>* People's servants (planners/providers of service/bureaucracy)</li> <li>* People's all categories (beneficiaries, non-beneficiaries, all others)</li> </ul>		

PEOPLES INVOLVEMENT IN HEALTH CARE DELIVERY SYSTEM AT VARIOUS LEVELS

(Maternal and Child Health and Family welfare)  
(Suggestive but not exhaustive)

1. VILLAGE LEVEL		
• Constitution of Health & F.W. Committees.		
• Training of Local Dais (T.B.A.)		
• Formation of Neighbourhood Committees (World level)		
• Mahilamandals		
• Satisfied Acceptors		
• Nehru Yuvak Kendras		
• Village Health guides		
• Anganwadi Workers (ICDS)		
• Youth organisations		
• Cultural groups		
• Village cooperatives		
(Panchayats to be actively associated)		
2. SUB-CENTRE LEVEL		
• Formation of Health & F.W. Coordination Committees (Officials/non-officials)		
• Organisation of Mahila Vikas Kendras (Health Visitor/ANM as convenor)		
3. PRIMARY HEALTH CENTRE LEVEL RURAL HEALTH CENTRES ETC.		
• Formation of P.H.C./Mandal level/RHc Health & F.W. (officials/Non-officials) (Medical officer as convenor)		
• Mandal/Block level - Mandal President Chairman		
4. URBAN AREAS		
• Neighbourhood/Basti/Ward level Committees.		
• Health & F.W. Coordination Committees (Formal/Informal leaders)		
• O.T.Cs.		
• Satisfied Acceptors		
• Non Govt. Organisations		
• Representatives of the people (Standing committee members of municipalities) & Chairman of Municipalities		
• Trade Unions of the local Industrial Units		
• Local Civic administration should provide leadership.		
5. DISTRICT LEVEL		
• District Health & F.W. Committees under the Chairmanship, of Chairman, Zilla parishad (Elected representative) (N.G.Os./Voluntary organisations to be represented)		
• O.T.Cs. and Seminars.		
• Peoples representatives (MLAs, MPs) to be involved as special invitees		
• Dist. Planning Boards also to review the progress under Health & F.W.		
• Local Industrial organisation Trade Union leaders		
• For Municipal Corporations separate Committees		
• Inter district visit/Intra district visits		
• Inter Sectoral Coordination.		
6. STATE LEVEL		
• State level Health/F.W. Coordination Committee under the chairmanship of the Hon'ble Minister for Health		
• Representatives from the Dist. level Zilla Parishads/Chairman of Municipalities		
• Representatives from trade Unions, Labour organisations, N.G.Os., Mahila Mandals		
• Inter State Visits		
• Good will visits/Educational Tours		
• Special Seminars		
• Inter Sectoral Coordination.		



## SERVICE AREAS OF PEOPLE'S INVOLVEMENT (Suggestie only)

S.No.	Programme / Service Activity
1.	All types of surveys - Baseline survey, Family Survey, Target couple survey, community diagnosis, situational Analysis.
2.	Maternal and child health, child survival and safe Motherhood Programmes.
a.	Early registration of Ante-natal cases (Domicileary visits/at the institution level)
b.	Utilisation of A.N. Services - attendance at the A.N. clinic and utilisation of all service components in A.N. care. (Emphasis - T.T. immunisation, use of Iron Folic Acid Caps)
c.	Natal Service - At home (Home delivery) - Institutional delivery. (PHSC, hospitals, nursing homes etc.)
	Delivery by trained Birth attendants of the area.
d.	Growth monitoring - planning and organisation of well baby clinics.
e.	Post Natal care/services - P.N. Visits/P.N. clinics.
f.	Infant care services.
g.	Immunisation services (mother and children)
h.	Nutrition - Breast feeding, weaning foods, Nutrition for pregnant mothers.
i.	Administration of Vit. 'A' Concentrate to children under 5 years.
j.	Distribution of nutriron/diet supplements/drug supplements.
k.	Prophylxis against nutritional anaemia (Iron Folic Acid Tablets).
1.	Training of Traditional Birth Attendants/Local Dais
3.	Curtive Services (Clinical)
1.	Out patient services
2.	In-patients services
3.	Referral services
4.	Patient Health Education

4. Management of diarrhoeal diseases
  1. Environment building for the use of oral rehydration therapy (Home made and supplied products).
  2. Preparation of oral fluids, its administration to the children
  3. Case reporting, control measures
  4. Hospitalisation.
5. Prevention and control of Acute Respiratory infections (ARI)
6. Family planning services - (Spacing and family limitation)
  1. Family survey, Eligible couples survey.
  2. Identification of couples for different F.P. methods
  3. Creating group acceptance for small family norm.
    - \* Delayed marriages
    - \* Spacing methods        - Depot Holder System
    - \* Teriminal methods     - Vasectomy, Tubectomy, Laparoscopic technique of sterilisation. Post Natal Sterilisations.
4. M.T.P. Services - Follow up of M.T.P./Tubectomy cases.
5. Recanalisation services
6. Health Education/ I.E.C.M. programmes. (Programme support communication)
7. Education relating to Enforcement of child marriages restraint Act for group/community acceptance.
  - \* Marriage guidance and counselling.
  - \* Counselling and advice on the advantages of the late marriages.
8. Programmes designed/planned for Adolescent girls and youth.
9. Environmental Sanitation (Community Health)
  - \* Home Sanitation
  - \* Provision of protected water - disinfection of water sources
  - \* Safe disposal of human excreta. (Building of sanitary latrines)
  - \* General sanitation and cleanliness
  - \* Anti mosquito, Anti fly measures.
  - \* Food Sanitation.
10. Personal Hygiene
  - \* Delousing Operations
  - \* Deworming Operations
  - \* Prevention/control of scabies.

11. Prevention and control of communicable diseases
  - \* T.B.; Leprosy, Malaria, Filariasis, J.E., A.R.I., AIDS.
  - \* National Health programmes
12. School Health services
13. Improvement of Birth and Death Registration
14. Literacy programmes for women-population education
15. Income generating programmes for women.
16. Constitution of village level/ward level/Basti level
  - \* Health and Family Welfare committees
  - \* Education Committees
  - \* Neighbourhood Committees
  - \* Mahila Mandals
17. Support to ongoing programmes being implemented for the women, mothers and children
18. Follow up of all service programmes.

### **Mortality Levels and Trends**

The United Nations (UN) estimates that infant and child mortality rates in developing countries declined by about 50% from the early 1950s to the early 1980s—from 281 deaths per 1,000 births among children under age five to 134 deaths per 1,000 births: Still the lower rate is seven times greater than in the developed world, where the under-five mortality rate is 19 deaths per 1,000 births.

### **Child Health-Better but Not Yet Good**

Widespread immunization has helped child survival, but the goal of universal immunization is still far from achieved. For example, more than 60% of children have been fully covered countries have yet to reach 20%. Also, diarrheal diseases afflicted one-fifth to one-third of children within the two weeks before the survey. Despite expanded efforts to treat the effects of diarrheal diseases with oral rehydration therapy, only about one-quarter of these cases were treated.

Pop.Rep. M.11(1992)



# 4 EFFECTIVENESS OF TRAINING PROGRAMME ON THE KNOWLEDGE OF ANGANWADI WORKERS

*Bansal A. K.*

## SUMMARY

An evaluation of the effectiveness of the three months training programme for Anganwadi workers was carried out in the Anganwadi Training centre, Mana Camp, Dist.Raipur (M.P.). A comparison of the pre and post training responses by an independent evaluator show a statistically significant gain in knowledge of Anganwadi workers.

## INTRODUCTION

Under I.C.D.S. programme, a package of services comprising of supplementary nutrition, Health check up, referral services, Health Education, Nonformal education are being provided in an integrated manner. The focal point for the delivery of these services is Anganwadi and the provider is Anganwadi worker. By judging, the key role an Anganwadi worker has to play, this study was carried out to assess the effectiveness of training programme on the knowledge of Anganwadi workers.

## MATERIAL AND METHODS

This study was carried out in Anganwadi Training centre, Mana Camp, Unit 111, Distt.Raipur(M.P.) from 15.11.88

24.02.89. All 59 AWWs attending the training course were included in the study. Pre and post training assessment was done by asking the AWWs to fill up pretested proforma consisting of 30 questions covering the syllabus provided by the Principal of the school with 'Yes' or 'no', or 'don't know' answers. Each question carries one mark for right answer and zero mark for wrong or do not know answer. These answer sheets had been examined by an independent examiner and the results were inferred by applying the suitable statistical tests.

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## RESULT AND DISCUSSION

Only 3.38% of AWWs scored more than 40% marks in the pretraining assessment. But at the time of post training assessment, the percentage has gone up to 67.79 (Tab.No.I.Annexure) There was a statistically significant increase in the mean score of AWWs from 12.45 at the time of pretraining to 47.88 on completion of the training (Tab.No.11) (Annexure)

The results of the present study are comparable with the results of the different studies conducted in the country from time to time for the evaluation of different training programmes by different authors likes, Udani,R.H. **et al**(1) Dwivedi,R.R. **et al** (2), Biswas,A.B. **et al** (3) and Aras,R.Y. **et al** (4)

## CONCLUSION

Such training programmes should be conducted from time o time and whenever considered necessary, it will be helpful in updating the knowledge of grass-root level-worker with the recent advances in Medical Science, and ultimately the community at large will be benefitted.

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## Annexure I.

Table No. I : PERCENTAGE OF MARKS OBTAINED BY AWWs.

n= 59

%ofmarks	Pre Training	Post Training
0 - 10	35 (59.32)	01 (01.69)
11 - 20	12 (20.33)	04 (06.77)
21 - 30	07 (11.86)	06 (10.16)
31 - 40	03 (05.08)	08 (13.55)
41 - 50	01 (01.69)	14 (23.72)
51 - 60	01 (01.69)	09 (15.25)
61 - 70	nil	09 (15.25)
71 - 80	nil	06 (10.16)
81 - 90	nil	02 (03.38)
91 -100	nil	nil
Total	59 (100)	59 (100)

*Figures in Parenthesis indicate percentage.*

Table No.II PRE & POST TRAINING DISTRIBUTION OF MEAN MARKS AND - STANDARD DEVIATION OF AWWs.

	Pre training	Post training
Mean marks (X)	12.45	47.88
S.D.	• 11.29	•18.87
%	20.63	79.36

$t = 12.89$ , Please than 0.01,  $df = 116$

The deciding factor in achieving lower mortality will be the political decision to give the issue priority and to dedicate to it the necessary resources, both of money and of skills.

—Dr. Nafis Sadik  
United Nation Population Fund



# 5 DEVELOPMENT OF HUMAN RESOURCES TO PROMOTE HEALTH AND DEVELOPMENT OF WOMEN AND CHILDREN - THE CHETNA EXPERIENCE

*Ms. Indu Capoor & Chetna Team*

## 1. INTRODUCTION

I would like to thank the organisers for giving me an opportunity to present a keynote address at this Third Regional Conference on "Peoples Involvement in the Health and Development of Women and Children." This paper is based on CHETNA Team experiences of 13 years in this field.

CHETNA has been involved in capacity building, training, and sensitization of various level workers. As a part of CHETNA's strategy development of training curricula, use of various participatory training methods, development of specific field tested audio-visual aids and reference material, are critical activities.

This paper will discuss the key factors required for Human Resource Development for health and allied personnel and community groups. It will highlight the importance of 'PARTICIPATORY APPROACHES' (Community involvement) to assess community needs, planning, training, monitoring and evaluation of health programmes.

The second critical factor for Human Resource Development is 'TRAINING' of various functionaries involved in this process. These may be individuals, grass root level workers, middle level supervisors or managers. Appropriate participatory training methodologies and audio-visual aids required for the different groups is discussed. The importance of Co-ordination and Co-operation among the community, grass root level workers, supervisors and, managers is highlighted using an example. Sensitization and orientation to the policy makers and leaders is suggested.

Based on our decade long experiences, the importance of 'INVOLVEMENT OF CHILDREN AND WOMEN AS HEALTH EDUCATORS', is

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discussed. Training approaches for teachers and other educators to educate the children is also explained. Innovative training approaches for women such as 'MELA' (fair), role-play and traditional medias such as puppets, folk songs, folk drama have been found to be very effective training methods.

Other factors which are discussed include the **INTEGRATED AND HOLISTIC APPROACHES IN TRAINING**', wherein 'PARTICIPATORY' and 'GENDER' approaches are highlighted. Since most of the functionaries in Human Resources Development are women, their gender needs during training have also been taken into consideration.

Lastly, some recommendations are suggested based on our experiences. We hope, our experiences in the field of curriculum development, participatory training methods and the development of audio-visual aids will be of use.

## **WHY HEALTH EDUCATION?**

To meet global health challenges, health education is the key component. The purpose of health education is to bring about improved health and well-being for all, through the promotion of healthy life styles, community action for health and conditions that makes it possible to live healthful lives.

This is a common goal of all those who engaged in health promotion, community mobilisation and health communication.

To facilitate this, CHETNA supports efforts of GO's, NGOs, individuals and others who are working in this field through conducting a variety of trainings for Orientation/sensitisation, familiarisation and Capacity building with overall goal of creating a healthy social climate, ensure supportive policies and influence attitudes and values. In the longer run it is expected to empower people with knowledge and health skills to improve their own health.

## **2. KEY FACTORS FOR HUMAN RESOURCE DEVELOPMENT FOR HEALTH**

To improve the overall health status of the community, empowerment of men, women and the children of the community plays an important role in leading to human resource development. The process of empowerment requires certain skills and appropriate management steps. The first step of management is to know the community, and the skill required is the ability to listen to them and their experiences. Active participation of the community from the stage of planning to evaluation in the health education process plays a crucial role. Specific training for various level functionaries is the second most important factor for human resource development.



## **2.1 LISTEN TO THE COMMUNITY**

The community which we aim to serve is our most precious human resource and efforts must be made to involve them in decisions affecting them from the planning stage itself. They also need to be involved in monitoring and evaluation of programmes. How can this be achieved? CHETNA has found that if the opinion of the members of the community members are actively sought either through a participatory needs assessment survey or through informal (yet structured) interactions, any programme implementation is much more effective. Here, one should not only approach influential village elders, as is often advised, but should actually listen to the people who are expected to be most affected by the decisions taken. Through our experiences we have found that even children and youth have a lot of useful suggestions to offer only if we listen to them !! Our Experiences, with Adolescent girls in a "Yuvati Shibir"\* (Adolescent Camp) organised by CHETNA amply highlights the importance of such events for the purpose of Strategic Planning.

Through fun and games, we not only communicated life useful messages to adolescents in this camp, but also had an opportunity to listen to their innermost concerns. At the end of this camp, we could plan a meaningful action strategy for addressing the needs of adolescents particularly, girls.

## **2.2 SENSITIZATION AND TRAINING FOR CAPACITY BUILDING AT VARIOUS LEVELS**

### **2.2.1 GRASS ROOT LEVEL WORKERS**

(Traditional Birth Attendants (TBA's), Village Health Worker (VHW), Village Health Guide (VHG), Anganwadi (Creche) Workers, Auxiliary Nurse Midwife (ANM) Balwadi (pre-school) workers).

Assessing the success of several health care projects in rural/tribal and slum areas all over India, it has been proved beyond doubt that the most effective health care providers are those that belong to the same community (particularly of the same class/caste) which they serve. Women tend to be more effective healers due to their inherent nurturing nature. Careful selection of the health workers is of prime importance. Giving regular and intensive training and imparting appropriate knowledge and skills through participatory methods (Games, roleplays, open ended stories, A.V. aids, Jigsaw puzzles) are extremely useful in ensuring that optimum learning is to be achieved. Further more, these methods persuade learners to express their views and experience, thus enhancing the results.

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\* Seminar on adolescent Girl's Health (1992).



One should start with basic curative skills (e.g. First Aid for minor wounds; including burns) which would give the workers a status/credibility in their community and slowly move on to more promotive and preventive health care concerns.

The critical element in the training of health workers is a regular and planned follow up support strategy particularly in the initial stages. Short duration (3-4 days) trainings over a period of time on a regular basis are found to be more effective than one time training input events as the absorption rate of these women is limited! Lack of time due to multiple burdens and child care responsibilities at home are contributory factors. In addition, training of a smaller number of workers at one time ensures that learning is maximized.

CHETNA team has experienced the effects of training health workers (many of them illiterate) in decade long experience, particularly in the Child Survival Project\*. We have seen that because illiterate women are unable to read and write, they concentrate more during trainings. This leads to greater learning.

Occasional larger events which bring together more health workers from different agencies further facilitate the learning process. Sharing of experiences strengthens the motivation and conviction of the workers.

One such event which contributed in building skills of health workers was the organisation of an innovative event e.g. "Health Mela" (Fair)\*\* which brought 150 women health workers together for 3 days spent in fun/frolic celebrations in a festive manner.

Enhancing "communication skills" for health education is another critical ingredient in the training of basic health workers. Their capacities must be built as animators, communicators and health educators. In addition, ensuring development of organising skills among them leads to their empowerment.

Use of traditional folk medias such as songs, dances, puppets games for teaching/learning have been found to be extremely effective. Organisation of Balmelas, gram yatras, roleplays and street theatre are particularly useful as they are an inherent part of the Indian traditional indigenous culture; their relevance and meaning in Indian culture helps people learn more effectively.

The health workers trained by CHETNA, are today confidently training other workers from the community.

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\* **Bridging the Gap** Child Survival Project Report (1984-1992).

\*\* **Health Mela** An Innovation approach to training women. CHETNA Experience (1990).

The learnings from training health workers over a decade can be summarized as follows:

- \* Select motivated workers (preferably women) belonging to the community.
- \* Use local language/dialect which is simple and easy to understand and relevant in their cultural community context
- \* Give workers information on Primary Health Care
- \* Train workers in participatory approaches at intervals
- \* Have short term trainings spread over a long duration.
- \* Continuously evaluate the learnings of workers and ensure regular follow - up support as and when required/requested
- \* Teach workers communication, organising and health education skills
- \* Provide workers with simple reference material in the local language
- \* Organise larger events to facilitate the sharing of experiences
- \* Listen and understand workers' social/cultural constraints and respond positively to them.
- \* Build confidence and self esteem necessary for problem solving at community level.

Local healers, following the traditional folk system of health care are another category of human resources available in majority of villages in India. They exist in the form of "experts" for conditions like jaundice, diarrhoea etc., bone setters, snake charmer's, vaidhyas, gunis, bhagats etc. Their potential lies in their experience, using locally acceptable and affordable resources, their services being accessible, available, and acceptable to the community.

CHETNA has interacted with healers to collect information on, herbs used to treat women's health problems and various traditional practices on maternal and child health\*. This information was largely found to be "scientific" and "rationale" as per Ayurvedic principles.

The key to training these workers lies in the critical element of validating their knowledge and promoting useful practices. Giving them the credibility and status which will give them confidence to "part" with the detailed information of their remedies which can then be disseminated and used on a larger scale.

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\* Proceedings of National Convention of Traditional Medicine and Maternal & Child Health Care, CHETNA Publication (December 1989).

(Lok Swasthya Parampara Samvarthan Samiti, a network of NGOs based at Coimbatore, is revitalising this resource through training).

### **2.2.2 SUPERVISORS/TRAINERS**

The supervisor is a key functionary in any health care delivery system. This can either be Lady Health Visitor (LHV), or Lady Supervisor as in the Integrated Child Development Scheme (ICDS) or a Sahyogini in the Mahila Smakhya Programme.

The “Supervisor”. presently, is merely viewed as a “fault finding” and monitoring person. In order that this critical functionary in the health care delivery system functions to her/his optimum level it is important that apart from training in technical knowledge, other skills are imparted which are critical to her/his effective functioning at the community level. These are co-ordination, team building, conflict resolution, role clarity, organisation, communication (particularly listening to health team members and community). In addition, planning, needs assessment, inbuilt monitoring, evaluation modalities and importance of follow up support are other skills required to be developed.

The above should be part of any training programme developed for supervisors. These should be imparted through participatory training methods (case studies, simulations, roleplays, group discussions etc.). Generally, lectures do not achieve the best results as most workers at this level have a rich experience. Unless teaching/learning methods utilize adult learning principles they may not be beneficial to a large extent.

Based on its experiences of over a decade, CHETNA has now shifted it's training efforts from training basic health workers to training their “Supervisors” as it has been shown that “Capacity Building” of this cadre of functionaries has a much wider impact and outreach. Also, supervisors being available at the field level can provide the much needed follow up support. The key to developing supervisory staff is to give them appropriate “Trainer” skills as that is the most critical role that they can play. These learnings are based on our several training programmes conducted for supervisors, particularly CHETNA's experiences of training 700 supervisors of the ICDS programmes in the state of Rajasthan\*.

### **2.2.3. LEADERS/MANAGERS**

Whenever we think of leaders of health care programmes, we usually conjure up the vision of a technical person, usually a doctor, who in his/her

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\* ICDS Enrichment Programme for Supervisors

A Training Strategy - CHETNA Publication (1990-1993)



routine professional training not prepared for leadership or managerial roles. Apart from possessing updated and accurate technical knowledge, all team leaders should be well versed in managerial skills for effective delivery of primary health care services. For this, the aspects which have to be included in the training are *team building*, motivation, coordination, project planning, monitoring and evaluation of delivery of primary health care services to regularly assess the impact of the programme.

In addition to this, team leaders must have clarity of the perspective and philosophy upon which the primary health care programmes are based. Participatory methods useful for training doctors are: case studies, simulations, group discussions and field visits to NGO managed health care programmes to observe the participatory managerial styles practiced by leaders of other organisations.

Also the doctor should be well versed in training skills as they are expected to play the role of a trainer and guide the team from time to time. She/he should also develop communication and advocacy skills which would assist her/him in listening to her/his team's concerns and communicating the same to his supervisors at the state level who usually develop policy.

In addition, it is also extremely necessary that from time to time the knowledge of the doctor is regularly updated by different methods: reading publications, attending seminars and workshops both specially organised and those organised by others.

#### **2.2.4. SENSITIZATION AND ORIENTATION OF POLICY MAKERS AND LEADERS**

Many a times, it is an unrealistic policy that leads to the poor implementation of primary health care programmes. If policy makers are regularly given information on ground realities and updated on constraints and concerns of implementing programme the policies that are made would be more realistic. Often Policy Makers heavily depend on academicians and researchers who sometimes have incomplete knowledge of ground reality.

Unless policies are based on the real needs and concerns of the people who are going to be directly affected by them, the interventions are unlikely to be meaningful/satisfactory.

Keeping the above in view, it is necessary to start any effort of human resource development with the sensitization /orientation of the policy makers and leaders, particularly of sharing the real concerns of the communities and for perspective building. For this, written documents and project reports from field based projects and dialogue with community leaders are of utmost

importance. Rather than being critical of the policies and programmes, suggesting alternatives and planning action researches is a more effective strategy. Demonstration of the results of “the difference” speaks more loudly than words.

## 2.3 CHILDREN AS HEALTH EDUCATORS

Children all over the world are plagued by serious health problems. Though eradication of factors that cause ill health, is not in the hands of children, they can still do a lot in their individual capacity and in groups to enhance the health of themselves, other children, families and communities. Every individual has not only a right to basic health knowledge and health care but also a duty to help others maintain and improve their health. The health of the community as a whole depends upon the health of each individual, whether he/she is an active or a passive citizen.

Children, apart from responsible citizens, are an agile and vibrant group which are open to learning. Furthermore, they have the time and courage to put the learning into practice and the sensitivity to form healthy habits.

Along with this basic potential of being open to new learning children are an immense resource often left untapped and under-utilized when their energy, time and enthusiasm are not channeled properly. For children, it is natural to pass on the information to peers, the younger and the older members of the family and community. This natural trait of children can be utilized to develop them into effective health educators. They can educate the young ones, the peers, family members and the community.

Any investment in children is an investment in future human resources. Thus, by involving children in health promotion we are not only preventing the present diseases, we are also producing a healthier future generation!

Children can contribute by:

1. Keeping themselves healthy by improving healthy habits to prevent diseases.
2. Taking action to prevent disease and promoting health in their families and communities. e.g. Cleanliness of house, village hygiene and sanitation, safe environment.
3. Treating conditions which they can treat themselves (e.g. first aid, ORS in diarrhoea etc.) and recognizing those which they cannot.
4. Taking action to improve their neighbourhood environment.
5. Passing on the knowledge to those who do not have it.
6. Giving assistance to others who need it.

### **2.3.1 TRAINING APPROACHES FOR CHILDREN (CHILD CENTRED HEALTH EDUCATION APPROACHES)**

Health knowledge can be imparted to children by various participatory methods on topics such as prevention of diseases, and nutrition awareness. For example games, songs and skits on diarrhoea or personal hygiene not only provide information, but also can promote the preventive aspects in action in a day-to-day manner. Apart from this they are enjoyable too!

These sessions can be taken through the curriculum and classes, trying to incorporate in the formal education. CHETNA implemented a three year pilot project on the Child -to - Child approach in formal and non-formal settings of Gujarat and Rajasthan\* on similar lines. This can also be done as short term interventions spread-over a period of time.

Celebrations of events like Nutrition week, Safety week, Children's Day, World Health Day, International Day for Action On Women's Health etc. can also be organised in such a fashion with activities like (learning from CHETNA's first hand experience), exhibitions, demonstrations, activities on health and nutrition in small groups or individual activities such as drawing or elocution competitions. We at CHETNA, have found that children learn best in pairs/groups and learn best by doing. Activities such as cleanliness drives in the community or personal cleanliness can also be undertaken to demonstrate the importance of personal hygiene and environmental sanitation. This will also serve a dual purpose of education to the community and to assist in the development of a strategy for mass awareness.

### **2.3.2 TRAINING APPROACHES FOR TEACHERS AND OTHER EDUCATORS**

When we talk of children, discussions of teachers naturally ensues.

As mentioned earlier, children can be very effectively utilized as partners for health promotion. And teachers have this agile group at their beck and call, in schools.

Presently, teachers are limited to teaching curriculum related subjects, which are often dry, and a limiting factor in learning. Having gone through the same educational system, teachers themselves end up passing academic knowledge to the children which is far removed from their real life situations.

Teachers can contribute a great deal in passing on the relevant and easy-to-implement preventive health messages to children in an activity oriented

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\* Growing Up Healthy publication of CHETNA is analytical documentation of this experience.



child centered manner, which will lead to the children being able to relate theory and practice of the messages.

CHETNA's Child-to-Child\* experience show that the teacher can be trained in simple health topics and can be encouraged, in turn, to take up these topics in an activity- oriented manner with children to make the experience enjoyable and knowledge relevant and usable.

Similarly, the NGO educators/functionaries working with children from a non-formal setting can also teach health to children in an innovative manner which will lead them to practice what they learn.

Such an investment will not only make the work of teacher and the educator more effective and interesting, it will soon show the effect on the ongoing health education programme in community, if any. It will reinforce health messages and improve the efficiency of the health services as the demand for "health" will be created.

This again can happen only if the teachers are themselves provided the experience of activity-oriented learning. In CHETNA's Child-to-Child programme, this is exactly what we practise. Without realising the importance and relevance of the methodology we cannot expect the teachers to utilize the methodology, but once they themselves go through the meaningful experience of learner-centered learning/training they realize its relevance for children.

During such trainings, the educators or the teachers need more than content knowledge (which She/he can acquire through books); They need a challenging experience, an experience which motivates them enough to go beyond their daily routine. Their inherent creativity should be recognised and programmes should be developed based on their wealth of experience with children.

The experience we have had during "Nutrition Week Celebration\*\*" (1-7 September 1993) is worth mentioning here. We engineered an atmosphere of non-threatening learning, suggesting the activity- oriented approaches through which nutrition education can be imparted to children and provided some technical inputs on nutrition. Above all, we gave teachers the freedom to think and the challenge to be creative. The outcome was a flood of innovative activities on nutrition like skits, songs, recipe- demonstration, most-nutritious- snack competition, creative advertisements on balanced-diet and other amazing suggestions!

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- \* Learning for Life Experiences of CHETNA in implementing Child-to-Child approach in rural and tribal areas in Gujarat and Rajasthan Status of India (1990)
  - \* Process Report of "Nutrition Week Celebration" (1993) CHETNA publication.

One week of health education activities reached 15,000 children.

The need of the day therefore, is not only to impart content training to the educators and teachers, as is routinely done, but more to provide them alternative methods of teaching health and posing a positive challenge to them to be motivated to move away from routine.

## **2.4. WOMEN AS HEALTH EDUCATORS**

Women, since time immemorial, have been taking care of the family utilizing their knowledge and skills to keep their families healthy and happy. However, due to the social structure they have been unable to recognise their own health concerns. It is our experience that when women are given an appropriate environment, they are able to articulate their concerns. If such opportunities are created and they are given the related knowledge, they will be able to take care of their own health which, would eventually help to make the family and community healthy.

During its decade long interaction with women, CHETNA has attempted to create awareness among women and educate them in health, childcare and hygiene concerns. Our experience indicates that unless women's status is improved, real progress cannot take place in society. And once women are equipped with knowledge and skills and are able to gain control over the decisions/actions, they can play a crucial role in bringing about a change at the family, society and community level. (What can a society expect from a person physically and mentally unfit)?

This realization assisted CHETNA in formulating integrated approaches focusing on women. But CHETNA's approach transcends and goes beyond this. This is well reflected in one of CHETNA's field projects on Water and Sanitation in Banaskantha District in Gujarat State.

Water plays a vital role in preserving health and can also be a potential source of many diseases. Since women are the largest consumers of water and also undoubtedly the most effective managers, our primary focus was to educate them in water management and to impart knowledge in water related and water borne diseases.

Once women became knowledgeable about diseases, they started conducting meetings in their own villages to educate the other members in the community.

CHETNA's interaction with the community not only helped to reinforce their knowledge, but also created a rapport at the personal level. The women expressed concern about their own health status. This felt need was, ultimately

conceptualized into a \*Women's Health Awareness and Diagnostic Camp at Varahi in Banaskantha District. A large number (300 women) came to be physically examined and get treatment in this one-day camp organised by CHETNA in collaboration with the local primary health centre and an NGO.

During interviews many of them stated that they had borrowed money for transport cost to avail this opportunity. They also felt it was important to seek medical help for their own good.

These statements indicate the level of awareness generated amongst them. They realized the importance of their own health, proved the social and cultural barriers which they overcame to take such a step.

#### **2.4.1 TRAINING APPROACHES FOR WOMEN**

Based on its experiences of working with women over a decade, CHETNA has realised that women (particularly illiterate) do not absorb much in structured didactic training situations. Not having attended schools, they are not used to sitting for a long time listening to lectures/watching. We have often experienced that watching slide shows/videos, due the dark atmosphere created for this purpose, village women even fall asleep!!!

Illiterate women have to be involved in participatory activities which give due importance to their rich experiences. Often pictures, games, Colouring charts, when used judiciously, can convey the messages much better, and can ensure optimum learning of women.

As a starting point, role plays based on traditional folk stories performed generously, interspersed with folk dance, songs and street theatre have been found to be very effective training methods for women.

An innovative approach to train women as experienced by CHETNA team is using a traditional festive format of celebration like a "MELA\*\*". By sharing experiences and listening to others, women learn much more effectively than by listening to lectures by so called "experts".

The mela organised by CHETNA introduced the factors affecting health of Indian Women through a role play which depicted social, cultural, political and religious factors which influence women's health followed by small group discussions facilitated by NGO health activists (Women). After ascertaining common concerns of the women present (mainly health workers) a suitable

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\* Women's Health Awareness and Diagnostic Camp organised by CHETNA (1993).

\*\* Health Mela, an Innovative Training Approach for Women

- The Chetna Experience (1990)



training design was worked out which, included among other things, gynaecological examination, hemoglobin estimation, designing posters for health education. During the evenings stalls were arranged where the women participated actively in competitions, dance, mehendi and rangoli decorations etc.

The Mela was also used for collecting data and some of the results were startling; inspite of being health workers majority of women were found to be suffering from anaemia. If the idiom "*practice what you preach*"; is to be believed than the women themselves needed iron supplementation before they tell others to do so.

### 3. INTEGRATED AND WHOLISTIC APPROACH IN TRAINING

Several government programmes fail to achieve the desired results and do not optimize use of resources as they address only a part of the community needs. For every new programme initiated by the government, usually a new set of workers is crated who have to undergo training for learning the strategy and content of the introduced programme. Instead of promoting implementation of several vertical programmes (e.g. Malaria eradication programme, Aids control, Anaemia prophylaxis programme) it is more effective that an integrated package is available at the community level which may be gender based; e.g. A worker to address women's and children's concerns etc.

However, there are some skills that every health educator whether a doctor or a grass-root worker should possess e.g. Communication Skills. Every worker is crucial as on it depends whether the new subjects introduced are understood by the community. Planning, co-ordination, motivation, monitoring and team work are other pre-requisites that each and every functionary of the health team should be well versed with.

Training on these topics can be imparted through use of case studies, simulations, structured exercises and role plays. Apart from programmatic integration there should be a holistic health care approach used in training which values peoples' knowledge, local health traditions and indigenous systems of medicines (Ayurvedic, homeopathy, Unani and Siddha approaches etc.).

We have experienced that when people's knowledge is appreciated and acknowledged any advice given to the community is more likely to followed as it is based on real concerns and is also likely to be more "user friendly".

### **3.1 PARTICIPATORY APPROACH AS A METHOD OF TRAINING:**

It has been experienced that use of participatory teaching/learning approaches in training is more effective for learning/teaching of adults. Here, value is given to the learners experience/expertise. To prove a point, many times seemingly illiterate Traditional Birth Attendant is far more likely to know how to manage normal birthing of abnormal foetal position rather than an M.D. (Gynaecology/Obstetrics).

Listening and valuing the learners experiences, solving problems, fears and doubts of trainees are critical starting points of any participatory training methodology based upon which practical curricula can be designed. In participatory training methods both the trainer/trainee are learners. This makes the process of training more effective. Presently a majority of the trainings imparted for health delivery follow the didactic approach of "lecturing by experts" which are so content heavy that retention of concepts becomes difficult.

### **3.2 GENDER NEEDS OF TRAINEES AND GENDER APPROACH IN TRAINING**

We have observed that planning of training for men and women workers is very different. Women health workers are often unable to attend long term training courses due to the multiple burdens of child care and domestic responsibilities. The Indian society views child care as a "primary" and often, sole (in reality) responsibility of the mother which prevents her from availing several self development opportunities.

Keeping the cultural reality in view, every training programme designed for women must budget for child care and provide physical (Creche) facilities for the same. The mother's learning is bound to be more effective when she is sure that the needs of her child/children are adequately met with.

In the long term "parent education" should be encouraged at the community level. This ensures that fathers take equal responsibility in child care which affords time for the self development of the mother.

## **4. RECOMMENDATIONS**

- a. For Human Resource Development for health, listening to the community for their needs is of utmost importance.

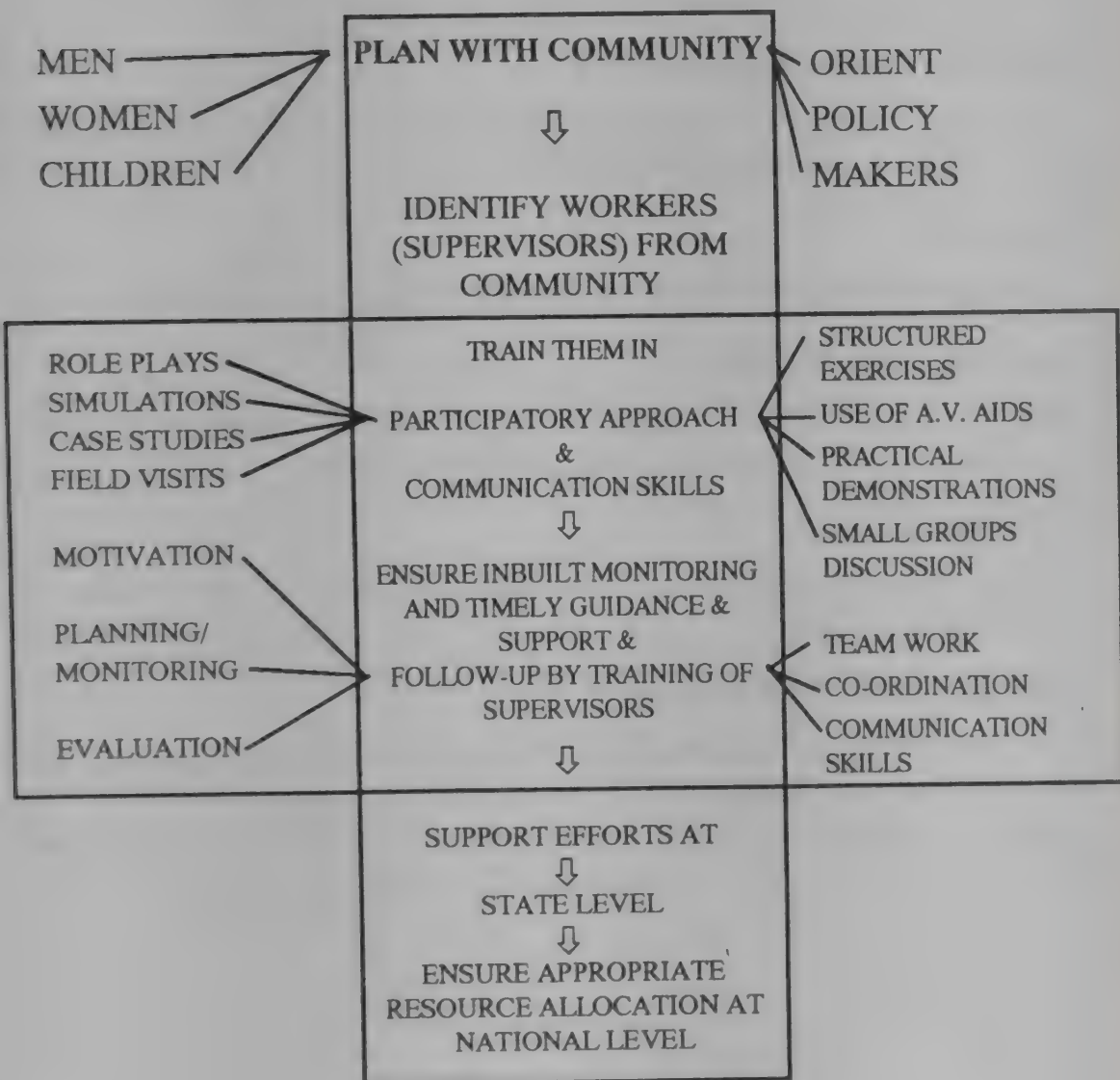
- b. Involvement of the community from the planning stage to the evaluation process is essential.
- c. Training methods, duration, objectives and content of the training should be specific according to type of trainees e.g. Grass Root Level Workers, Supervisors, Managers, Policy Makers, Women, Children, Teachers etc.
- d. Adults learn in a different way than children. Therefore, while developing curriculum, it is essential to keep adult learning principles in mind.
- e. Integrated, participatory and gender approaches should be included in all types of trainings related to women's health and development. Men also need to be gender sensitised.
- f. Co-ordination, Co-operation and Team spirit among grass-root level workers, supervisors and managers is essential.
- g. Specific Audio- Visuals aids (low-cost) should be developed according to requirements.
- h. Traditional media should be encouraged for use during training and especially, for health education to the community since, people have control and experience in this as well as they are low-cost.

The ultimate goal of trainings should be to lead to 'EMPOWERMENT' of the workers and the community, which is a essential part of Human Resource Development.



# TRAINING STRATEGY FOR HEALTH CARE WORKERS FOR PRIMARY HEALTH CARE

## A CONCEPTUAL FRAMEWORK



# **TRAINING OF THE TRADITIONAL BIRTH ATTENDANTS**

## ***SELECTION CRITERIA:***

Experienced, trained/untrained, community acceptability, middle aged, (mothered children), active and motivated.

## ***TRAINING METHODOLOGY :***

Participatory, experiential learning with emphasis on “learning by doing” with emphasis on practicals and practice.

## ***Duration :***

Short duration (3-4) days over a period of time on a regular basis.

## ***Teaching Aids/Methods :***

Especially illustrated books, posters, puzzles, charts, ilfradoll, role plays, games, songs, audio-visuals, practicals, demonstration.

## ***APPROACH :***

Start from local practices, dai’s role, anatomy, socio-medical issues and then the content.

## ***CHETNA’S EXPERIENCE:***

CHETNA has trained more than 1000 TBAs in Gujarat, Rajasthan, Uttar Pradesh and Andhra Pradesh states of India and the experience is enriching. The methods used enable the TBAs to grasp the content easily and an intense discussion on socio-medical issues like infertility help to clear their perception.

# TRADITIONAL BIRTH ATTENDENTS (TBA)

## “LEARNING BY DOING”

TBA	Training needs/content		Methods/ Medium		Topics impart	which she can at the community
	With experience	Without experience	With experience	Without experience		
Trained	As a change agent trainer, health educator, *ANC, *PNC childcare. Management Complications. Socio medical issues like abortion, sex discrimination infertility, gender issues. Gynaecology. Training skills, Counselling motivation. (adding inf.)	As a change agent, health worker how to conduct safe aseptic delivery ANC, PNC. Child care	Largely illustrated Books Hand outs Folders Charts (more written + Picture) Practical demonstration.	Practical demonstration Charts Books	Literate	ANC PNC Safe delivery neonatal and Childcare Contraception abortion Infertility Gynaecology
Un trained	As a change agent, Health educator Aseptic and safe delivery, ANC, PNC, childcare Sex discrimination Abortion, infertility Gynaecology	As a dai, as a health worker, How to conduct aseptic delivery. ANC PNC Practical demonstration	Role plays Games Songs Picture Books Activity Practical demonstration	Practical demonstration Role plays Games Songs Picture Books Activity	Illiterate	ANC PNC Safe delivery neonatal and Childcare contraception abortion Infertility Gynaecology

ANC: Antenatal Care  
PNC: Postnatal Care



## TRAINING OF TEACHERS

<p>Teachers</p> <p>Not oriented to the Subject</p>	<p>Content</p> <ul style="list-style-type: none"> <li>* Conceptual Clarity of the subject</li> <li>* Basic information of the subject</li> </ul>	<p>Methods/Aids/Techniques</p> <ul style="list-style-type: none"> <li>* Small Group Discussion</li> <li>* Symbolic Presentation</li> <li>* Lecture/ discussion</li> <li>* Demonstrations</li> <li>* Use of available Aids</li> <li>Reference material</li> </ul>
<p>Oriented to the Subject</p>	<ul style="list-style-type: none"> <li>* Relevance of the Subject in a wider perspective</li> <li>* Team Work</li> <li>* Supervision/ Monitoring</li> <li>* Self development</li> <li>* Skill Development</li> </ul>	<ul style="list-style-type: none"> <li>* Self Learning exercises (Structured exercise)</li> <li>* Discussion</li> <li>* Mock Sessions</li> <li>* Reading material</li> </ul>

## *Section 5*

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### *Background Materials*





# *Part 1*

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*South East Asia Regional Bureau  
(SEARB) For International Union for  
Health Promotion and Education*



# **1 South East Asia Regional Bureau (SEARB) FOR International Union for Health promotion and Education**

The South East Asia regional Bureau (SEARB) is a regional set up of the International Union for Health promotion and health Education (IUHPE)

The Bureau framed and adopted its own constitution and bye-laws. They were registered under the Karnataka Societies Act, 1960 under Sl.No.106/85-86, dated 24-2-1985. The Bureau supplemented and supported the constitution and bye-laws of the IUHPE. Certain articles and sections of the constitution and bye-law were amended as required by the income-tax authorities to get recognition. In its preamble, the constitution provided to the Bureau strong, sound and scientific foundations. The constitution ensures an unique structure for the Bureau to grow and develop.

## **Organisation**

At the headquarters, the Bureau has two functional divisions - Management and Technical. These divisions have sections and working groups to serve all aspects of management and all branches and specialities of health education. Suitable organisations at the level of countries, provinces or states, districts or cities are also provided. Bureau covers 11 countries of the South East Asia - Bangala Desh, Bhutan,, Burma. India, Indonesia, Maldives, Mongolia, Nepal, North Korea, Sri Lanka and Thailand.

The aim of the Bureau shall be to promote, encourage and contribute to the development of health education for the advancement of health of all people throughout the South East Asia Region. For this, the Bureau seeks to:

- \* Maintain relations with non-governmental organisations of provincial or state or National or Regional or International character concerned with promotion of health:
- \* Establish effective link between organisations and people working in the field of health education (and allied areas) in the various countries of the Region and enable them to pool their knowledge and experiences,
- \* Encourage and facilitate Region-wide exchange of information and experiences on all matters relating to health education (information,



communication and education) including programmes, research, professional preparation, training, methods, techniques, use of mass media, etc.

- \* Promote the improvement of professional preparation in health education for health educators, information and community development personnel, social workers, volunteers in relief work, etc. :
- \* Promote scientific research, including field studies concerning health education methods, media and its various specialities;
- \* Promote development of informed public opinion on matters relating to healthful living according to local people's physical, biological, social, cultural and economic environment.
- \* Maintain and strengthen relations with the Regional Organisations of the WHO , UNESCO, UNICEF, FAO, ILO and other International and bilateral organisations for the advancement of health education throughout the Region;
- \* Promote integrated health education development in health and development plans at regional, national and local levels and facilitate effective implementation and management of the health education component;
- \* Promote identification, testing and use of local traditional media and methods of communication and indigenous community organisation and leadership;
- \* Promote education for better health specially among women and children, among those living in rural areas and urban slums and among the under-privileged and neglected communities;
- \* Encourage introduction and strengthening of education for healthy living among students and teachers and personnel in the education system of the countries;
- \* Facilitate development and demonstration of appropriate effective health education soft-ware, methods and techniques suitable for different service components of primary health care including selfcare;
- \* Encourage and facilitate maintenance of high and recognisable standards of professional preparation in health education in communication and allied subjects and in pre-service and inservice training of health and allied personnel;
- \* Encourage and promote production of appropriate high quality audio, visual and other types of information, communication and educational materials for health education;
- \* Provide consultancy and advisory services in the areas mentioned above.

The significant achievements of the Bureau and its chapters are recalled  
ow:

- Undertook four scientific research projects;
- Promoted high standard of professional preparation in health education  
for health and allied personnel;
- Exchanged latest information, experiences and skills in health education  
/ primary health care;
- Publishing Bureau's journal "Health Education in South East Asia"  
(formerly SEARB Bulletin) every quarter;
- Organised several professional enrichment seminars;
- Organised two regional conferences, an inter state consultation work-  
shop, seminars and group educational activities;
- Organised exhibitions on primary health care, health education methods  
and media, intersectoral co-ordination, cessation of tobacco smoking and  
chewing;
- Facilitated production of appropriate and effective educational software  
for all channels of communication;
- Advocated health and health education in different forums at all levels;
- Rendered many consultancy services to government and non-govern-  
ment institutions, organisations and individuals and actively collaborated  
with them in many activities, projects and programmes;
- Represented the IUHPE at the WHO South East Asia Regional Commit-  
tee Meetings and advocated further strengthening of health education and  
the IUHPE;
- Participated in the IUHPE World Health Education Conferences held at  
Dublin, Houston and Helsinki contributing several scientific papers from  
the region;
- Attended the IUHPE Executive Committee meetings held at Tokyo and  
Paris besides the planning meetings held at Helsinki and Toronto;
- Formulated proposals for further strengthening the Central Health Edu-  
cation Bureau, Government of India to implement National Health  
Policies of the Government of India; formulated proposals for establish-  
ing "National Institute of Rural Health and Family Welfare at GANDHI  
GRAM, TAMIL NADU.

These could not have been achieved, but for the significant contributions  
made by the members voluntarily as and when required; whatever recognition  
the Bureau/Chapters have derived in these years is entirely due to this pooling

and sharing of their knowledge, experience and skills besides values and attitudes.

- SEARB developed and maintained cordial working relationships with government departments, non-government organisations and international and bilateral agencies at various levels particularly with the following organisation:

### **International Organisations**

- World Health Organization, South East Asia Regional Office,
- UNICEF, SOUTH CENTRAL ASIA.,
- UNESCO
- UNFPA
- FAO ;
- UNDP ;
- World Bank ;
- USAID ;
- DANIDA ;
- Ford Foundation ;
- John Hopkins University ;
- Rock Feller Foundation ;

### **Government Organisations**

- Directorate - General of Health Services, New Delhi ;
- Central Health Education Bureau, New Delhi ;
- Directorate of Advertising & Visual Publicity, New Delhi ;
- Department of Social Welfare & Women's Development, New Delhi ;
- All India Institute of Hygiene & Public Health, Calcutta ;
- All India Radio ;
- National Institute of:

Health and Family Welfare, New Delhi ; Mental Health and Neuro Sciences, Bangalore ; Tuberculosis, Bangalore; Educational Research and Training, New Delhi; Rajendra prasad Institute of Ophthalmology, New Delhi; Public Co-operation and Child Development, Bangalore

- Indian Council of Medical Research, New Delhi;
- Regional Institutes:

Kidwai Memorial Institute of Oncology, Bangalore; Regional Cancer Institute, Thiruvanthapuram;



- State Directorates of Health and Family Welfare Services of Andhra Pradesh, Karnataka, Kerala, Punjab, Tamilnadu and Delhi Administration;
- State Directorates of Medical Education ; Public Instruction or Education; Women and Child Development ; Social Welfare ; Information and Publicity, Agriculture ; Animal Husbandry ; Rural Development and Rural Water supply and sanitation;
- State Institutions of Administrative Training; Public Co-operation; Dairy Development, Health and Family Welfare Training Centres, Medical Colleges;
- National and State programmes like: Health and Family Welfare, Primary Health care; Integrated Nutrition Projects; Integrated Rural Water Supply and Sanitation ; Leprosy Eradication; Tuberculosis Control ; Prevention of Blindness; Prevention and control of cancer; Prevention and Cessation of smoking; school health services; community mental health services.

### **Voluntary Organisations**

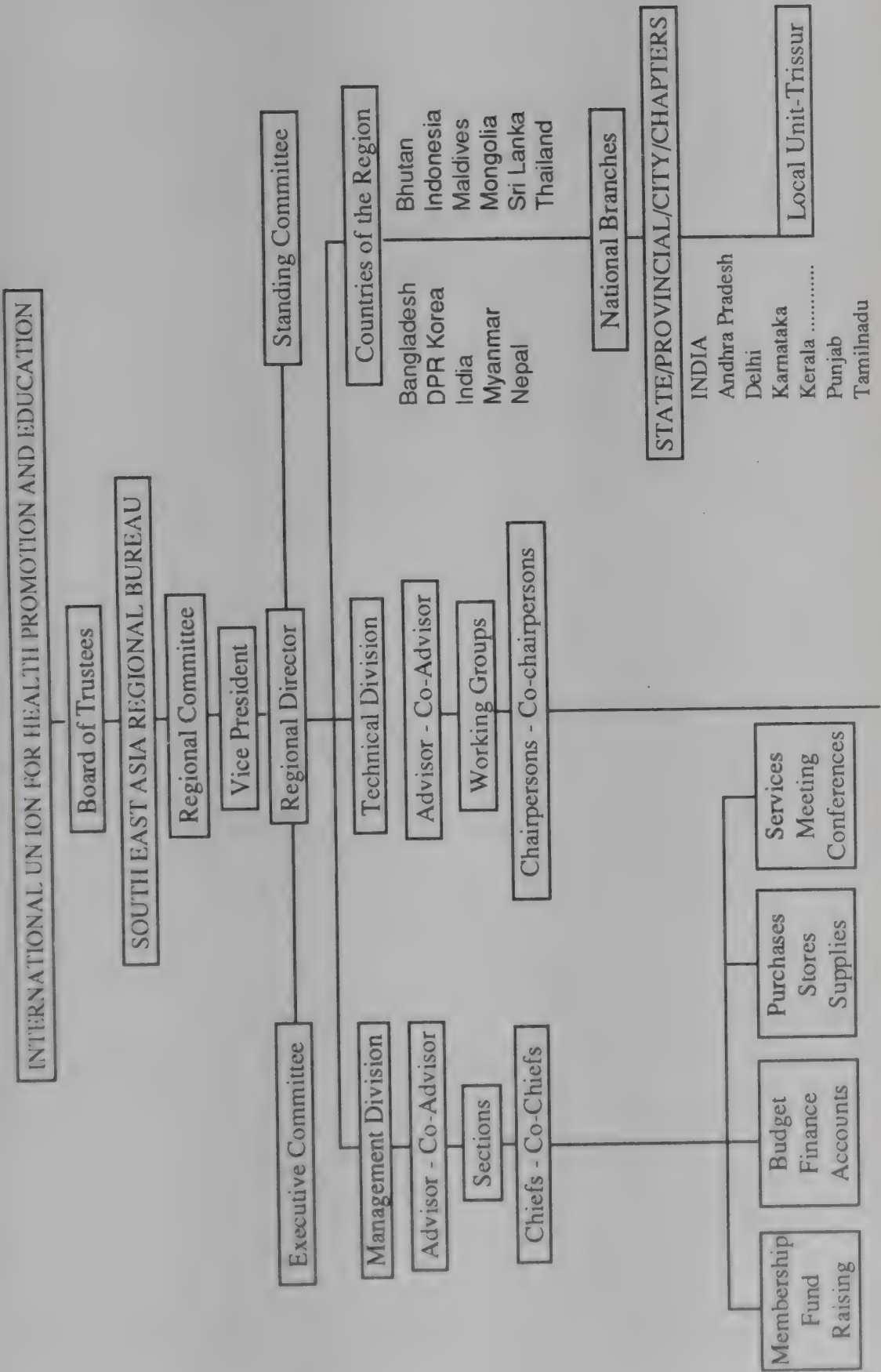
- Indian medical Association, New Delhi;
- Tuberculosis Association of India, Delhi;
- The Gandhigram Institute of Rural Health & FW Trust;
- Institute of Engineers, Bangalore;
- Private Medical Colleges; Kempegowda Institute of Medical Sciences, Bangalore;
- Dr. Ambedkar Medical College, Bangalore; M.S. Ramaiah Medical College, Bangalore ; St. John's Medical College, Bangalore;
- Karnataka State Leprosy Council, Bangalore;
- Voluntary Health Association, State Branches;
- Indian Society of Health Administrators, State Branches ;
- Family Planning Association of India, State Branches ;
- Applied population Research Trust, Pavagada ;
- Chaitanya Institute for Rural Development, Hubli ;
- Centre for Health Education Development, Madras ;
- EMMA Association, Madras ;
- Drug Action Forum, Bangalore ;
- Christian Medical Colleges, Vellore and Ludhiana

Holding informal periodical meetings to pool ideas, to develop programmes / strategies, to find solutions for pressing problems and to take joint decisions, was the most successful method employed by the Bureau. So far three Regional Committee / General Body meetings were held. They elected office bearers of the Bureau for three year terms and transacted statutory and other important business.

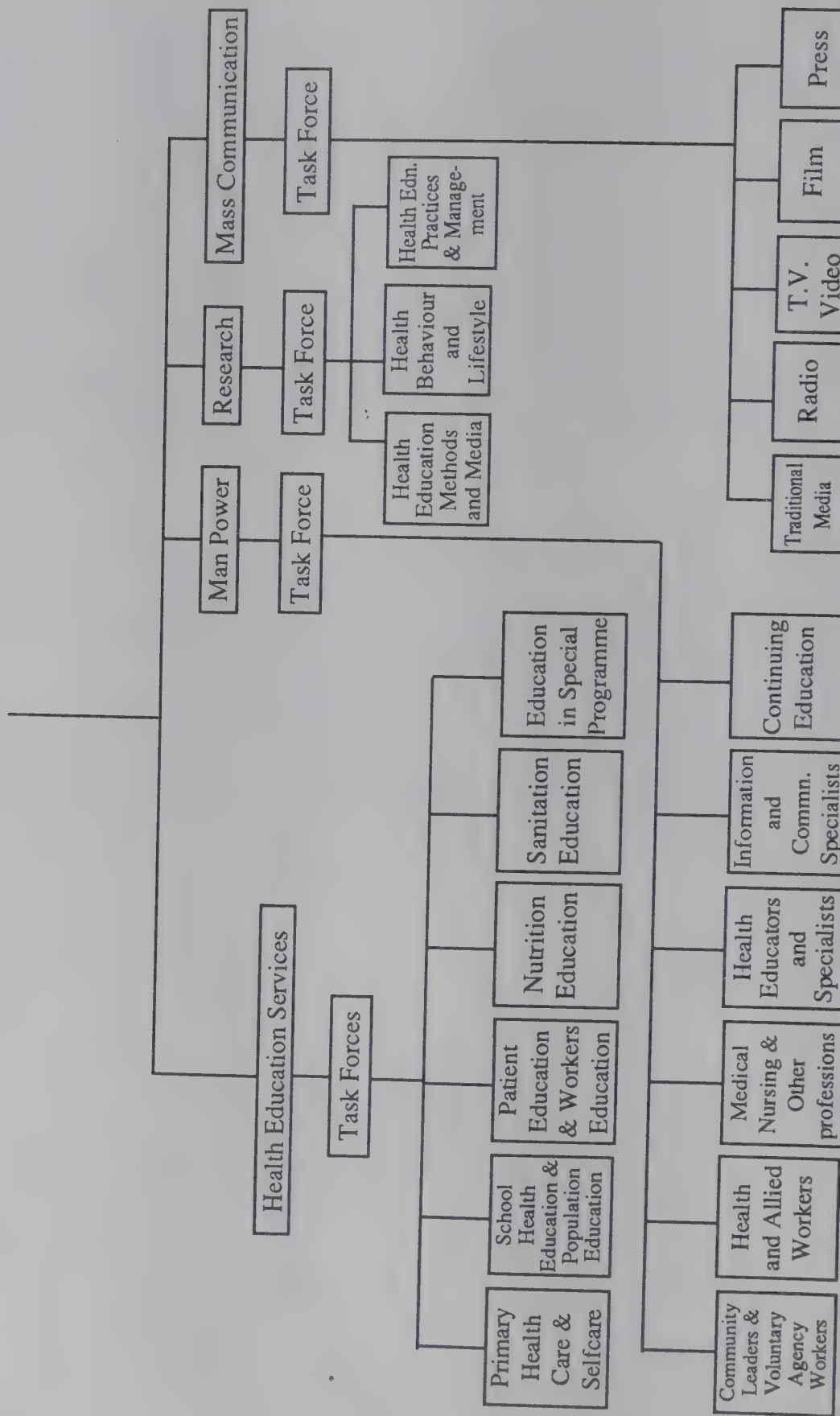
Several Executive Committee meetings were conducted to review the progress of the on going programmes, to examine audit reports and financial position, to approve budget estimate and to suggest new programme directions. Scientific sessions were included at these meetings which proved very useful and popular. Documents resulting from these scientific programmes have been valuable as professional resource materials. All these accomplishments were initiated, supported and guided by the office-bearers of the Bureau (Refer list of office bearers)

## **Membership**

Members, their expertise, commitment and contributions have been the greatest asset of the Bureau. Except for the dedicated work of a few volunteers committed to the promotion of health of the needy, there were no resources worthy of mention at the inception of the Bureau. Promotional measures undertaken by this team attracted members to get enrolled under different categories of membership. These members in turn recruited new members. Till 1992 the Bureau enrolled 633 members, including 301 life members. In 1993 77 life members and 8 part life members have joined.







# IUHPE-SEARB Office-Bearers

Designation		1985-88
Vice-President		Prof. Varunee Surasiti
Regional Director		Dr. V. Ramakrishna
<b>Divisions</b>		
Technical Advisor		Dr. V. Kapali
	<i>Co-Advisor</i>	Dr. C. Achuthan
Management Advisor		Dr. H. C. Agrawal
	<i>Co-Advisor</i>	Dr. S. Abdulkareem
Hon. Treasurer		Dr. S. R. Narayana Murthy
Hon. Editor		Dr. T. K. Parthasarathy
<b>WORKING GROUPS</b>		
H. Edn.	<i>Chairperson</i>	Dr. (Mrs.) Sumathy S. Rao
Servies	<i>Co-Chairperson</i>	Mr. H. B. Subbe Gowda
Research	<i>Chairperson</i>	Prof. J. S. Chauhan
	<i>Co-Chairperson</i>	Dr. C. Shivaram
Manpower	<i>Chairperson</i>	Mrs. Khurshida Khhanom
	<i>Co-Chairperson</i>	Dr. P. V. Aswath
Comm. & Media	<i>Chairperson</i>	Mr. K. Balasubramanyam
	<i>Co-Chairperson</i>	Mr. Karmalki
<b>SECTIONS</b>		
Membership &	<i>Chief</i>	Dr. M. T. Hema Reddy
Fund Raising	<i>Co-Chief</i>	Smt. M. Lakshmi
Budget &	<i>Chief</i>	Mr. S. R. Narayana Murthy
Accounts	<i>Co-Chief</i>	Dr. V. M. Bagley
Conferences	<i>Chief</i>	Mr. V. J. Sundara Vadivelu
	<i>Co-Chief</i>	Dr. H. Pramila
Stores, Supplies & Purchases	<i>Chief</i>	Mr. Settappa
	<i>Co-Chief</i>	Mrs. R. Indiramma

## IUHPE-SEARB Office-Bearers

1988-91	1991-94
Prof. Varunee Surasiti	Mr. P.P. Shrestha
Dr. V. Ramakrishna	Dr. V. Ramakrishna
Dr. S.H. Hassan	Dr. K.A. Pisharoti
Dr. G. Raman	Dr. K.B. Makapur
Dr. S. Abdul Kareem	Mr. H.B. Subbe Gowda
Dr. B.S. Sehgal	Dr. K. Balachandra Kuru
Mr. S.R. Narayana Murthy	Mr. S.R. Narayana Murthy
Mr. T.K. Parthasarthy	Mr. T.K. Parthasarthy
Dr. (Mrs.) Sumathy S. Rao	Dr. (Mrs.) Sumathy S. Rao
Mr. H.B. Subbe Gowda	Prof. Pankaj Mehta
Dr. J. Ramakrishna	Dr. S.C. Gupta
Dr. K. Basappa	Mr. Bapiraju Sarma
Dr. V. Kapali	Mr. Baldevraj
Dr. Devi B. Shrestha	Dr. M.S. Rajanna
Mr. K. Balasubramanyam	Mr. K. Balasubramanyam
Ms. T. Padmasini Asuri	Fr. Emmanuel M. Pillai
Dr. M.T. Hema Redy	Dr. M.T. Hema Reddy
Dr. H.Pramila	Prof. M.O. Vergheese
Mr. S.R. Narayana Murthy	Mr. S.R. Narayana Murthy
Mr. M.V. Bapiraju Sarma	Mr. K.N. Krishna Murthy
Dr. P. Krishna Murthy	Dr. V. Kapali
Dr. M.S. Rajanna	Ms. T. Padmasini Asuri
Mr. Settappa	Mr. Settappa
Smt. M. Lakshmi	Smt M. Lakshmi



## *Part 2*

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*Dr. J. Jayalalitha 15 point  
Programme for Child Welfare*



# 1

## **Dr. J. JAYALALITHA 15-POINT PROGRAMME FOR CHILD WELFARE, GOVERNMENT OF TAMIL NADU.**

1. Nurturing the human potential is a universal responsibility and there is no greater human potential than the millions of children on whom progress and National development depend. The National and State policy, especially in recent times, has focussed on human resource development and perhaps for the first time in history we also have the means - material, technological and institutional to achieve this. The emphasis has also rightly moved from ensuring just child survival to ensuring growth and development of children.

2. The basic needs of children are known - safe water, nutritious food, preventive and primary health care, clean environment, basic education, loving care. Towards achieving these for all children of the state, especially to the disadvantaged group, the Tamil Nadu Government has now formulated the state programme of Action (SPA). The 15-point programme has drawn the most critical areas from the detailed state programme of Action prepared by all the concerned Departments. The SPA is to be referred to for elaboration of the action points mentioned in this document. The 15 points are listed below according to major headings:

### ***MATERNAL & CHILD HEALTH:***

1. Increase average birth weight of children to 3 kg.
2. Elimination of Vaccine preventable Diseases;
  - a. elimination of poliomyelitis.
  - b. Elimination of neonatal tetanus.
  - c. Elimination of measles cases and deaths.
3. Reduction of Infant mortality to less than 30 per 1000:
  - a. Elimination of deaths due to diarrhoea in children under five years.
  - b. Elimination of deaths due to acute, respiratory infections.

### ***NUTRITION:***

4. Reduction of severe and moderate malnutrition among children.



5. Elimination of Micronutrient Deficiencies:
  - a. Elimination of Vitamin A deficiency in children under five years.
  - b. Elimination of Iodine deficiency.
  - c. Reduction of Iron deficiency (Anaemia) in children 0-5 years and mothers.
6. To make all hospitals and maternity centres “Baby Friendly”.

### ***FAMILY WELFARE:***

7. To liberate women from the shackles of early and frequent child bearing:
  - a. Raising the age of marriage for girls to 21 years/
  - b. Spacing birth intervals to 3 years.

### ***EDUCATION:***

8. Universalisation of Compulsory primary education ensuring 5 years of primary education for every child by legislation and by campaign.
9. Raising women’s literacy and status.

### ***DRINKING WATER SUPPLY & ENVIRONMENTAL SANITATION:***

10. Safe drinking water supply and better access to sanitary facilities at all children’s centres.

### ***CHILD LABOUR:***

11. Elimination of child labour in a phased manner.

### ***GIRL CHILD:***

12. Popularising of Girl protection scheme:
  - a. Improvements to Girl child protection scheme.
  - b. Improve status of girl children.
13. Eradication of the social evil of female infanticide in Tamil Nadu.

### ***CHILDHOOD DISABILITY:***

14. Prevention of childhood disability and early detection for rehabilitation.
15. Early identification of congenital heart diseases and free surgeries for children.

## ***GENERAL ISSUES:***

The 15-point programme will give special attention to the needs of children who are most deprived and most in need of protection.

These include the girl child, children of the urban poor and those working in hazardous industries.

In order to ensure that the 15 point programme is implemented effectively, special mechanisms will be introduced to implement and monitor progress. These include:

- a. Establishment of a high level task force and a Research and Monitoring Cell for the programmes of children.
- b. Child Welfare Centres to be made Child and Women's Welfare Centres.

This programme was inaugurated on 11th November 1993 in TAMIL NADU.

# POINT ONE

## *INCREASE AVERAGE BIRTH WEIGHT OF CHILDREN TO 3 KG.*

**GOAL:** The average birth weight of children born in Tamil Nadu will be 3 Kg.

1995: Increase in mean (average) birth weight to 2.9 Kg.

1998: Increase average birth weight to more than 2.9 Kg.

2000: Increase average birth weight to 3 Kg.

### *CURRENT STATUS:*

It has been well established that birth weight of the child is an important factor in child survival and development. In a developing country like ours many children start their life as an infant with a disadvantage of low birth weight. We have adopted the norm of less than 2.5 Kg for defining low birth weight. The low birth weight rate in Tamil Nadu is still reported to be around 30%. The average birth weight for babies in Tamil Nadu has been reported to be around 2.8 Kg. We need to pay attention to health and nutrition of adolescent girls and mothers. Health and Nutritional status before pregnancy and nutrition and health during pregnancy influence the growth of the foetus.

Major factors contributing to extensive maternal malnutrition include early marriage, early pregnancy, short birth intervals, anaemia, iodine deficiency, heavy work during last trimester etc. Reports indicate that the problem is perhaps greater in urban slums. It is believed that a birth weight of 3 Kg will greatly increase child survival and reduce infant mortality and at the same time, will be safe for the mother.

### *ACTIONS:*

1. Extend and strengthen nutrition and health services to cover all mothers in urban and rural areas by extending TINP/ICDS services supported by health inputs from special urban projects like IPP-V and regular rural health services.
2. Nutrition and health education to women especially adolescent girls, newly married couples and pregnant women to focus on right age at marriage, right age at first pregnancy, nutrition, rest and importance of weight gain during pregnancy, etc.



3. Iron and folic acid supplementation to reduce the ill effects of anaemia. (See point 5-c also).
4. Implement the programme for control of iodine deficiency disorders by universal iodisation of salt. (See point 5-b also).
5. Implement food supplementation from sixth month of pregnancy to six months after delivery for improving the nutritional status of mothers and the infant.
6. All maternal and child nutrition and health programmes will adopt a strategy of intra uterine growth monitoring to reduce the incidence of low birth weight.

## POINT TWO

### *ELIMINATION OF VACCINE PREVENTABLE DISEASES:*

- A. ELIMINATION OF POLIOMYELITIS
- B. ELIMINATION OF NEONATAL TETANUS
- C. ELIMINATION OF MEASLES DEATHS AND CASES

#### *A. ELIMINATION OF POLIOMYELITIS*

GOAL: To be the first state to eliminate poliomyelitis.

1995: Achieve polio-free Tamil Nadu.

1998: Sustain elimination status.

2000: Eradicate poliomyelitis.

#### *CURRENT STATUS:*

The number of paralytic polio cases in Tamil Nadu has dropped from 3394 in 1985 to 420 cases in 1992. One district, Nilgiris, is polio-free for the past 3 years and two other districts, Kamarajar and Kanyakumari are polio-free for the past one year. According to the latest Coverage Evaluation Survey, the OPV3 coverage is 89.5% in Tamil Nadu.

#### *ACTIONS:*

1. The reporting of Acute flaccid paralysis will be made mandatory under section 56 of the Tamil Nadu Public Health Act 1939. All health care providers (Government and private) will be directed to report cases.
2. The coverage during containment immunisation and mop-up rounds will be increased to 100%.
3. 100% coverage of oral polio vaccine (5 doses) will be achieved through special efforts. Catch-up rounds in urban slums, SC/ST colonies, tribal and inaccessible areas will be conducted every year on National Immunisation days. Special campaigns will be conducted in North Arcot, South Arcot and Chengai-MGR Districts which together contribute to 50% of polio cases in Tamil Nadu. Additional resources will be allocated for additional vaccine requirements for primary immunisation 5 dose schedule, for catch-up rounds, for mop-up rounds and for containment immunisation.

## ***B. ELIMINATION OF NEO NATAL TETANUS***

**GOAL:** To be the first state to eliminate neo-natal tetanus.

**1995:** \* 100% coverage with Tetanus Toxoid 2 doses.

\* 100% deliveries attended by trained persons.

\* 100% districts NNT free.

**1998:** Sustaining achievement

**2000:** Sustaining achievement

### ***CURRENT STATUS:***

There were 56 cases of NNT in 1992. Thirteen (13) districts already have reported zero cases of NNT. According to the latest Coverage Evaluation Survey 1993, the TT2 coverage is above 90% and the percentage of deliveries attended by trained persons is 50% in rural areas and more than 90% in urban areas.

### ***ACTION:***

1. Tetanus toxoid coverage of pregnant women will be increased to 100% by taking special steps to register Antenatal mothers early, in the first trimester itself; by conducting special immunisation camps/sessions and by ensuring booster dose of TT at least 4 weeks before expected date of delivery.
2. All Traditional Birth Attendants in Tamil Nadu will be trained on "clean deliveries", use of disposable delivery kits and timely referral for complications.
3. Institutional deliveries in HSCs and PHCs will be promoted by providing appropriate facilities.
4. The public will be educated on the importance of clean delivery practices, use of disposable delivery kits and reporting of neonatal tetanus.
5. Disposable delivery kits will be made available in sufficient quantities for distribution to every pregnant women well before the expected date of delivery.
6. Reporting of tetanus will be made mandatory under section 56 of TNPH Act 1939.
7. Additional resources will be allocated from Area projects like TINP, IPP-V, DANIDA for communication, ensuring availability of disposable delivery kits and reporting fee to trained TBAs.



## ***C. ELIMINATION OF MEASLES DEATHS AND CASES***

**GOAL:** To be the first state to eliminate measles deaths and cases:

1995: 95% reduction in measles deaths and 90% reduction in measles cases

1998: Sustain achievement

2000: Elimination of measles deaths and cases.

### ***CURRENT STATUS:***

The number of measles cases in 1992 is 4873 as compared to 10029 in 1985. According to the latest Coverage Evaluation Survey, the Measles Vaccination coverage is 75.1% and varies from 50-95% in different districts.

### ***ACTIONS:***

1. The reporting of measles will be made mandatory under section 5 of the Tamil Nadu Public Health Act 1939. All health care providers (Government and private) will be directed to report cases and deaths due to measles.
2. The coverage for Measles vaccine to be improved to 100%
3. A second dose of measles vaccine will be given to infants immunised before the 9th month of age.
4. Children above 1 year of age will be given a second dose of measles vaccine from vaccine supplies unused during immunisation sessions as a special state policy.
5. Vit A concentrate 2 lakh I.U. will be administered to all children affected by measles during outbreaks.
6. GOI clearance will be obtained for ring immunisation of all children under 3 years of age during measles outbreaks in surrounding 500 population in rural areas and 10,000 population in urban areas irrespective of previous immunisation status.
7. Correct case management of all acute respiratory infections and possible measles complications will be ensured through training of all health care providers, both in the public and private sector.

## **POINT THREE**

### ***REDUCTION ON INFANT MORTALITY TO LESS THAN 30 PER 1000 LIVE BIRTHS:***

- A. ELIMINATION OF DEATHS DUE TO DIARRHOEA IN CHILDREN UNDER FIVE YEARS.
- B. ELIMINATION OF DEATHS DUE TO ACUTE RESPIRATORY INFECTION.
- C. REDUCTION OF INFANT MORTALITY RATE TO LESS THAN 30 PER 1000 LIVE BIRTHS AND REDUCTION OF PERINATAL AND NEONATAL MORTALITY RATES BY 50% FROM CURRENT LEVELS.

#### **A. ELIMINATION OF DEATHS DUE TO DIARRHOEA IN CHILDREN UNDER FIVE YEARS.**

**GOAL:** To be the first state to eliminate deaths due to diarrhoea in children under 5 years.

1995: \* ORS available 24 hours at every village and urban slum through depot holders.

\* ORS use rate for diarrhoea management is 100% among health care providers in the public and private sector.

\* Deaths due to diarrhoea among 0-5 year children reduced by 30%

1998: Diarrhoea deaths among 0-5 year children reduced by 60%

2000: Diarrhoea deaths among 0-5 year children reduced by 90%

#### ***CURRENT STATUS:***

In Tamil Nadu, the Oral Rehydration Therapy (ORT) use rate is 82% (Coverage Evaluation Survey, 1993). The incidence of diarrhoea among 0-5 year children in 1991 was 1.74%.

Among private medical practitioners, the use of ORS needs to be improved and the use of anti-diarrhoeal drugs and antibiotics for watery diarrhoea needs to be discouraged.

Many unsafe preparation of ORS are now available in the market. The WHO-UNICEF citrate formula with the GOI logo alone is to be recommended.

## **ACTIONS:**

1. ORS (WHO-UNICEF citrate formula) will be made available in sufficient quantities on 24 hour basis at every village and urban slum neighbourhood level through appropriately trained depot holders.
2. Availability of commercial preparation of ORS WHO-UNICEF citrate formula in the open market will be ensured at the lowest possible price and of good quality.
3. Government and private sector health care providers will be trained on the correct case management of diarrhoeal diseases.
4. The public will be educated on i) the use of Home Available Fluids and ORS for prompt home management of diarrhoea ii) timely referral if dehydration develops and iii) continued and additional feeding during diarrhoea.
5. All district hospitals to establish DTUs and all taluk hospitals and PHCs to establish ORT corners for management of diarrhoea.

## **B. ELIMINATION OF DEATHS DUE TO ACUTE RESPIRATORY INFECTION**

**GOAL:** To ensure that no child under 5 years dies due to Acute Respiratory Infections (ARI).

1995: Reduce ARI mortality by 30%

1998: Reduce ARI mortality by 60%

2000: Reduce ARI mortality by 90%

## **CURRENT STATUS:**

Acute Respiratory Infections (pneumonia) causes 30% of all 0-5 year deaths in Tamil Nadu. In rural areas use of wood as fuel for cooking causes indoor smoke pollution which contributes to ARI while overcrowding and air pollution affect urban children. Most mothers seek the help of private sector medical practitioners for treatment for ARI. The antibiotic, "Co-trimoxazole" is available both in government and private health care facilities, but the case management has not been standardised among all health care practitioners.

## **ACTIONS:**

1. Training will be organised for government as well as private health care providers on the correct case management of Acute Respiratory Infections.



2. Availability of co-trimoxazole will be ensured in all Health Sub-Centres, PHCs, and hospitals on a regular basis.
3. Purchase policies will be simplified to allow local purchases of co-trimoxazole by PHC Medical Officers.
4. Smokeless chulahs will be promoted and their use will be strictly enforced in all ICDS/TINP/Noon Meal Centres to prevent indoor smoke pollution. Public will be educated on the use of smokeless chulahs.
5. The public will be educated on appropriate home management and timely referral if complications develop.
6. Referral facilities at Taluk and District Hospitals will be strengthened for diagnostic and treatment procedures for severe pneumonia.

### **C. REDUCTION OF INFANT MORTALITY RATE TO LESS THAN 30 PER 1000 LIVE BIRTHS AND REDUCTION OF PERINATAL AND NEONATAL MORTALITY RATES BY 50% FROM 1990 LEVELS**

**GOAL:** To reduce Infant Mortality Rate to less than 30 per 1000 live births in Tamil Nadu.

**1995:** To reduce Infant Mortality Rate to 50 per 1000.  
To reduce perinatal and Neonatal Mortality Rates by 30% from 1990 levels.

**1998:** To reduce Infant Mortality Rate to 40 per 1000.  
To reduce perinatal and Neonatal Mortality Rates by 40% from 1990 levels.

**2000:** To reduce Infant Mortality Rate to <30 per 1000.  
To reduce perinatal and Neonatal Mortality Rates by 50% from 1990 levels.

### **CURRENT STATUS:**

The Infant Mortality in Tamil Nadu is 57 per 1000 live births (1992). Currently nearly 70% of the Infant Mortality occurs in the first one month of life and especially in first week of life (Neonatal and perinatal Mortality). This component of IMR has not shown any declining trends whereas the postneonatal component (1 month to 1 year) has been declining due to reduction in vaccine preventable diseases and control of diarrhoeal deaths. Therefore, any further

reduction of IMR in Tamil Nadu would need a reduction of the Neonatal and perinatal Mortality rates.

The causes of infant deaths are low birth weight, prematurity, birth asphyxia, respiratory infections and diarrhoea. The causes of perinatal mortality (still births) are mainly delivery complications and lack of emergency obstetric care.

In rural areas, more than 50% of births are conducted at home by untrained birth attendants. There is a lack of emergency transport facilities for mothers and babies to reach the referral hospitals in time.

Even if mothers do reach the hospitals, there is a lack of facilities at the Taluk and District Hospitals for Emergency Obstetric Care and Newborn Care.

### **ACTIONS:**

1. The nutritional status of pregnant women will be improved by adequate food supplementation especially during second and third trimester to ensure a minimum weight gain of 7 Kg. so that the baby's birth weight can be increased to 3 Kg.
2. Institutional deliveries in Health Sub centres, Primary Health Centres and hospitals will be promoted by improving facilities for delivery.
3. A clean delivery booth will be constructed in every village where a trained Traditional Birth Attendant can conduct normal deliveries under aseptic conditions.
4. Traditional Birth Attendants will be trained to conduct clean deliveries, to practice simple resuscitation techniques for management of birth asphyxia and in the recognition of high risk conditions in newborns such as birth weight < 2 Kg., jaundice, respiratory distress and congenital anomalies, for appropriate and timely referral.
5. Referral facilities at Taluk and District Hospitals will be improved for providing Emergency Obstetric Care and Newborn Care. Low cost neonatal care units for referral care of newborns will be established in all district and taluk hospitals in the entire state.
6. Emergency transportation will be organised through panchayats for emergency referral of mothers and babies.
7. Mothers will be educated on home care of newborn infants (especially low birth weight infants) by promotion of early breast feeding, colostrum feedings, provision of warmth, prevention of infection and exclusive breast feeding.

## POINT FOUR

### REDUCTION OF SEVERE AND MODERATE MALNUTRITION AMONG CHILDREN

**GOAL:** Tamil Nadu will ensure that current levels of severe and moderate malnutrition among children are reduced by half.

**1995:** Reduce severe energy protein malnutrition (EPM) to less than 6% and moderate malnutrition to less than 25% in children under 3 years.

**1998:** Reduce severe EPM to less than 5% and moderate EPM to less than 20% in children under 5 years.

**2000:** Reduce severe EPM to less than 5% and moderate EPM to less than 15%

### **CURRENT STATUS:**

EPM is one of the major nutrition problems among children. Children who suffer from lack of energy and protein in their diets are not able to grow to their full genetic potential and weigh less for their age or have too low heights for their age or suffer from both low weight and height for their age. Severe forms of EPM can manifest as marasmus, Kwashiorkor, depending on a number of individual factors.

The State Government's objective is to ensure that by 2000 AD all children under 3 years weigh more than 70% of the standard weight for age. The current levels of severe malnutrition is expected to be around 4-8% in different districts while moderate malnutrition is expected to be around 25-30%.

### **ACTIONS:**

1. Extend and strengthen existing maternal and child nutrition programmes in the state with specific focus on reaching the currently excluded hamlets and most needy areas.
2. Strengthen supplementary nutrition programme for children under 3 years with weaning food and for children above three years with noon meal.
3. Involve parents and community in growth promotion and monitoring of children's nutritional status.
4. Improve and extend preventive health care and referral facilities.
5. Strengthen nutrition health education for mothers and community.



## **POINT FIVE**

### **ELIMINATION OF MICRONUTRIENT DEFICIENCIES:**

- A. ELIMINATION OF VITAMIN A DEFICIENCY IN CHILDREN UNDER 5 YEARS.
- B. ELIMINATION OF IODINE DEFICIENCY
- C. REDUCTION OF ANAEMIA IN CHILDREN AND MOTHERS

#### **A. ELIMINATION OF VITAMIN A DEFICIENCY IN CHILDREN UNDER 5 YEARS.**

*GOAL:* To be the first state to eliminate Vitamin-A deficiency in children under 5 years.

- 1995: Reduction of Vitamin A deficiency by 75% of current levels in children under 3 years.
- 1998: Elimination of Vitamin A deficiency.
- 2000: Sustain achievement.

#### ***CURRENT STATUS:***

Vitamin A deficiency has been recognised as a major controllable public health and nutrition problem. In Tamil Nadu, the prevalence of Vitamin A deficiency has declined from 1.9% among pre school children and 5% among 5-12 year children in 1981 to 1% and 2.7% respectively in 1991. Urban and rural children seem to be affected equally.

Vitamin A deficiency probably increases mortality and morbidity in children and is precipitated by frequent infections like diarrhoea, measles and ARI. Lack of awareness of importance of vitamin A rich foods in the diet and poverty limiting access to Vitamin A rich foods, contribute to the low in-take and consequent deficiency. Weaning children suffer most since many of the Vitamin A rich foods are excluded from their diet due to traditional beliefs that such foods would cause diarrhoea.

#### ***ACTIONS:***

1. Provide Vitamin A in 2 lakh IU doses to all children between 6-36 months and to child population at-risk at six months interval.
2. Awareness generation on importance of Vitamin A and Vitamin A rich foods.

3. Promote exclusive breast feeding for the first 4-6 months of life.
4. Promote consumption of Vitamin A rich foods among pregnant and nursing women.
5. Intensify nutrition education to increase production and consumption of Vitamin A rich foods especially among vulnerable groups.

## **B. ELIMINATION OF IODINE DEFICIENCY**

*GOAL:* Tamil Nadu Government will ensure that iodised salt of prescribed quality is available all over Tamil Nadu for prevention of iodine deficiency.

1995: Ban sale of non-iodised salt in the state.

1998: Achieve satisfactory iodisation levels in at least 90% of salt tested in market places in identified endemic districts.

2000: Universal Consumption of iodised salt.

### ***CURRENT STATUS:***

Iodine deficiency disorders (IDD) is a major public health problem that has serious effects on child survival and development, and results in both physical and mental disorders. The most common visible effect is goitre. But many more children and women of child bearing age suffer from less obvious but more serious conditions like, impaired mental function, poor intellectual performance, lowered I.Q. affecting school performance, muscular disorders and impaired co-ordination and sluggishness.

In pregnancy, iodine deficiency causes spontaneous abortions, still births and infant deaths. It may also result in birth of cretins. Thus IDD has significant effect on human development.

Data is not available on prevalence of iodine deficiency disorders in Tamil Nadu. Scattered studies in Trichy, Nilgiris and pudukottai districts show an endemic pattern of prevalence of goitre. Indicators such as high frequency of abortions, high incidence of premature birth, low birth weight and still births show that there may be a much higher level of iodine deficiency in the community than officially acknowledged.

Iodised salt is produced in Tamil Nadu by private manufacturers. In Tamil Nadu, the Salt Commission of Government of India has so far permitted 46 plants with a capacity of 500,000 MT for manufacture of iodised salt. Production is only 100,000 MT for want of demand.

## ***ACTION:***

1. Establish an IDD cell at state level for which Government of India support is now available.
2. Notify compulsory iodisation under PFA and ban sale of non-iodised salt for domestic consumption.
3. Assess the extent of IDD district wise by comprehensive surveys, identify endemic areas for intensified interventions.
4. Explore the possibilities of double fortification in order to ensure that progress made under iron fortified salt and iodised salt programmes are consolidated.
5. Awareness generation on importance of micro nutrients and their deficiencies and measures to tackle them.

## **C. REDUCTION OF IRON DEFICIENCY (ANAEMIA) IN CHILDREN (0-5 YEARS) AND MOTHERS**

**GOAL:** To reduce iron deficiency in children and mothers by 30% from 1990 levels.

1995: Reduce 1990 levels by 10%

1998: Reduce 1990 levels by 20%

2000: Reduce 1990 levels by 30%

## ***CURRENT STATUS***

In Tamil Nadu, 40% of 0-5 year age children and 50% of pregnant women suffer from anaemia. This has been a major and chronic problem and there is no declining trend. It is related to general levels of malnutrition and reflects less access to food and iron-rich food, worm infestations and greater physical stress and burden. The adverse effects of malnutrition and anaemia among children and pregnant women are: a high incidence of children born with low birth weight and maternal mortality. As a prophylactic measure, iron fortified salt is used in Noon Meal Centres. The current production is 6,000 MT annually.

## ***ACTIONS:***

1. Implementing iron supplementation, resolving operational problems in logistics of supply, outreach and compliance by beneficiaries and improving quality and packaging.



2. Strengthening of supply and distribution of therapeutic dose of iron and ensure compliance by beneficiaries.
3. To explore possibilities of double fortification in order to ensure that the progress made under iron fortification of salt is consolidated.
4. Awareness generation on importance of micronutrient and their deficiencies and measures to tackle the problem.
5. To intensify nutrition education to increase production and consumption of foods rich in iron.

## POINT SIX

### MAKE ALL HOSPITALS AND MATERNITY CENTRES “BABY FRIENDLY”

**GOAL:** To be the first state in India to make all hospitals and maternity centres “baby friendly” to promote breastfeeding.

1995: All hospitals with over 1000 deliveries annually to become “Baby Friendly”.

1998: All hospitals and maternity centres in the state to become “Baby Friendly”.

2000: Correct infant and child feeding practices by all mothers.

### **CURRENT STATUS:**

More and more mothers use infant formula and feeding bottles and there is a decline in the practice of breast feeding both in urban as well as in rural areas of Tamil Nadu.

In Order to curb the aggressive marketing of breast milk substitutes, the Infant Milk substitutes, Feeding Bottles and Infant Foods (Regulation of Production, supply and Distribution) Act was passed in December 1992 and entered as Law in August 1993. Enforcement of this Act can be facilitated by directing all hospitals and maternity centres to strictly follow the Ten Steps to successful breastfeeding developed by UNICEF/WHO.

The “baby friendly” institutions will be awarded certificates of recognition by the National Task Force of the Baby Friendly Hospital Initiative Programme.

### **ACTIONS:**

1. All hospitals and maternity centres, both public and private will be directed by Government of Tamil Nadu to become “baby friendly” and strictly follow the Ten steps to successful breastfeeding.
2. All health care providers, both public and private will be trained in the Ten steps and in Lactation Management.
3. The Law related to Infant Milk substitutes, Feeding Bottles and Infant Foods (Regulation of production, supply and Distribution) will be strictly enforced in the state and suitable monitoring and enforcement mechanisms will be introduced.

4. The public will be educated on the benefits of breastfeeding and the dangers of infant formula and bottle feeding.
5. Maternity Leave and benefits will be suitably modified to enable mothers to exclusively breastfeed their babies for the first four months of life, and continue breastfeeding with appropriate weaning food well into the second year.



## **POINT SEVEN**

### **TO LIBERATE WOMEN FROM THE SHACKLES OF EARLY AND FREQUENT CHILD BEARING**

- A. RAISING THE AGE OF MARRIAGE FOR GIRLS TO 21 YEARS
- B. SPACING BIRTH INTERVALS TO THREE YEARS

#### **A. RAISING THE AGE OF MARRIAGE FOR GIRLS TO 21 YEARS**

*GOAL:* The age of marriage for girls will be raised to 21 by 2000 AD.

#### ***CURRENT STATUS:***

The legal age of marriage is 18. The social, cultural and economic pressures result in many rural girls getting married before they can achieve physical, psychological and emotional maturity. It is essential that every girl child gets the opportunity to fully develop her potential as a self-reliant individual. The ill effects of early marriage and pregnancy get reflected in low health and nutritional status for the mother and child, low social, educational and economic status of girls and women.

#### ***ACTIONS:***

1. Intensive awareness creation for raising age of marriage to 21.
2. Curriculum and educational system to be modified to encourage all girls to complete education.
3. All out of school girls and women to become literate.
4. Intensive campaign among male youth, parents and elders on adverse effects of early marriage and pregnancy.
5. Compulsory registration of all marriages and enforcing laws to punish offenders.
6. Skill development programmes for adolescent girls and income-generating schemes and self-employment opportunities for rural women.
7. Formation of cohesive groups for adolescent groups and women for building self-confidence and self-defence.

## **B. SPACING BIRTH INTERVALS TO THREE YEARS**

**GOAL:** To reduce Crude Birth Rate to less than 15/1000 and increase birth interval to 3 years.

1995: Reduce Crude Birth rate (CBR) to 18/1000.

Ensure average birth interval is 3 years.

1998: Reduce Crude Birth Rate to 16/1000.

Ensure minimum birth interval is 3 years.

2000: Reduce Crude Birth Rate to 15/1000.

### ***CURRENT STATUS:***

The Crude Birth Rate in Tamil Nadu is 20.8 in 1991 (SRS). The Birth rate trends in the state show a steady decline and the achievement of Tamil Nadu is remarkable when compared to other states. However, a continuing reduction in the CBR is essential to be maintained if maternal and child health status is to be improved to reach the 2000 AD goals.

It is being recognised that achievement of sterilisation targets and 'couple protection rates' do not absolutely correlate with trends in birth rates. Factors that tend to influence the prevention of births are many viz: literacy and educational status of women, age at marriage being above 21 years, chances of survival of children as influenced by birth weight above 3 Kg. and birth interval 3 years or more. Currently, the Family Welfare programme in Tamil Nadu is focussed predominantly on female sterilisation and contraception and not sufficiently on the factors listed above.

### ***ACTIONS:***

1. The achievement of Family Welfare goals will be recognised as an inter-departmental and inter-sectoral responsibility. Programmes will be planned jointly by concerned sectors and departments in a coordinated manner to address the issues of age at marriage, birth interval, birth weight, age at last birth and availability and acceptance of a range of contraceptive services.
2. Particular attention will be focussed on organising women at village level for enabling health action by all members of the community through peer pressure. This will help to shift the programme away from being an "incentive-based" programme to a "community movement".
3. Intensive political and administrative support to the programme will be provided through regular monitoring and review at Panchayat, District and state levels.

## POINT EIGHT

### UNIVERSALISATION OF PRIMARY EDUCATION ENSURING 5 YEARS OF PRIMARY EDUCATION FOR EVERY CHILD BY LEGISLATION AND BY CAMPAIGN.

*GOAL:* To achieve Universal Primary Education.

- 1995: \* All children 6-7 years to be enrolled in formal school and all 8-11 years in formal or non-formal stream.
- \* Reduction in overall drop-out rates by 40% of 1990 levels
- 1998: \* All 6-11 years enrolled in formal schools, staying on to complete upto class 5.
- \* All out-of-school children upto 14 years to be enrolled in Non-formal education.
- \* Reduction in overall drop-out rates by 75% of 1990 levels.
- 2000: All children aged 6 to 11 will have at least 5 years of primary education.

### *CURRENT STATUS:*

The literacy rate in Tamil Nadu is 62.66%. However, the disparity between male and female literacy is still glaring (male: 73.7% female 51.3%). The drop-out rate at the primary level has declined steadily from 54.9% in 1961 to 19.3% in 1991. The same gender disparity exists. SC/ST girls have the highest drop-out rate of over 30%. What is required now is the final concerted push, as a priority to improve the quality of education to achieve the goals.

### *ACTIONS:*

1. Tamil Nadu is the first state to declare that Legislation on Compulsory Primary Education will be prepared. Legislation to be passed by Assembly in next session and to be operationalised by 1994-95 academic year.
2. Wide publicity on legislation and create awareness among parents on need to send children to school, especially girls.
3. Compulsory registration of all primary school-aged children through Village Education Committees and Mother Teacher Councils who



will also ensure that all children are enrolled and attending school and will have a strong role in local management of the school.

4. Priority targetting of girls, SC/ST children, working children and other educationally backward children.
5. Recognition and awards for panchayats, wards, block, and districts which achieve full enrolment, retention and completion.
6. Quality of education to be improved for better teaching learning for every child to attain the minimum levels of learning; through in-service teaching training, introduction of MLL approach and provision of adequate facilities and materials.
7. District plans will be prepared for all districts and implementation will be monitored by District Collector.
8. Establish linkages with total literacy and post-literacy campaign activities and with Early Childhood Care, Education and Development.
9. Flexibility of the system to allow adaptation to local needs, with possible introduction of shift systems, varying school timings and calender especially in child labour intensive areas.
10. Integration of children with mild to moderate disabilities into the mainstream of formal education.
11. Ensure access to pre-school services for children (3-5 years) with improved activity-based learning as the main approach.
12. Introduce expanded non-formal activities through Education Volunteers Service scheme and other NFE approaches.

## POINT NINE

### RAISING WOMEN'S LITERACY AND WOMEN'S STATUS.

*GOAL:* By 2000 AD, state to achieve 100% Female Literacy.

1995: 80% female literacy.

1998: 90% female literacy.

2000: 100% female literacy.

#### *CURRENT STATUS:*

There is a wide disparity (22%) between male and female literacy rates (M: 73.75% and F: 51.33%). Women constitute a majority of the estimated 7 lakhs illiterates in the 15-35 age group.

The importance of female literacy to social development is an internationally established fact. As female literacy increases, the birth rate and the infant mortality rate falls. Also, a literate mother is more likely to ensure that all her children get an education as can be seen in the Arivoli districts where education has become important for everyone.

While efforts to achieve Universal Primary Education (UPE) will ensure that there will be no new generations of illiterates by the year 2000, the current adult illiteracy must be eradicated.

#### *ACTIONS:*

1. The total Literacy Campaign (TLC) launched in 1991 will be completed by 1994 covering the entire state. This last phase of the Arivoli will be undertaken with renewed commitment.
2. The Post Literacy Campaign (PLC) will continue up to 1996 with the momentum of the TLC spirit being maintained. PLC will have a strong component on awareness and empowerment of women.
3. TLC/PLC activities, especially the social mobilisation and formation of Village Education Committees to be directly linked with UPE activities.

## POINT TEN

### **SAFE DRINKING WATER SUPPLY AND BETTER ACCESS TO SANITARY FACILITIES AT ALL CHILDREN'S CENTRES AND HABITATIONS.**

**GOAL:** One source of safe water will be provided for every 150 persons within 1 Km. and coverage of households with sanitary facilities will be increased to 25% households in rural and 90% in urban areas.

#### ***CURRENT STATUS:***

The current level of water supply coverage is one source for every 300 persons. Many areas have problems of poor quality of drinking water because of high levels of chemical content and salinity. Increasing number of wells are becoming dry because of poor rainfall and over-exploitation of ground water for irrigation and industries. Many schools, Primary Health Centres, Health sub-centres, Child Welfare Centres, Anganwadis and TINP centres do not have drinking water and sanitation facilities.

For diarrhoeal diseases to be reduced, water supply, sanitation and health services must be provided as an integrated package. At the moment, these three components are not being done in a convergent manner.

9% of rural households and 60% of urban households have sanitary facilities. The main problems has been a combination of low demand as well as low coverage of sanitation programmes.

#### ***ACTIONS:***

1. Integrated approach to water, sanitation and Diarrhoeal Diseases Control.
2. Provide sanitary latrines and water supply to all government community service institutions such as schools, health centres, child welfare, ICDS and TINP Centres.
3. Support to research and development programmes for improved and appropriate technology for provision of drinking water in problem areas and find suitable cost effective techniques for improved re-charging of the ground water.
4. State level apex body to be set up to deal with problems related to water and district-level monitoring mechanisms to ensure sustained availability of drinking water.



5. Operation and maintenance by village women mechanics and village committees through introduction of a decentralised maintenance system.
6. Ensure sustainability of existing sources and improved quality drinking water in addition to increasing coverage levels.
7. Awareness creation and social marketing to promote a clean environment and increased demand for sanitary latrines.
8. Introduction of environmental sanitation as a package which includes handling of drinking water and food; disposal of waste water, excreta and garbage; personal hygiene and environmental cleanliness.
9. Subsidy for families below poverty line for household sanitary latrines.
10. Development of local production, delivery and marketing capacity for sanitary latrines.
11. Development of alternative approaches for sanitation promotion such as establishment of revolving funds, sanitary marts, linkage to Bank loans at block-level.
12. Introduction of school sanitation through curriculum development for maintaining personal hygiene by students and through provision of personal hygiene kits to all pre and primary schools.

## POINT ELEVEN

### ELIMINATION OF CHILD LABOUR IN A PHASED MANNER.

**GOAL:** Bonded child labour, child labour in hazardous industries (children under 15 years) and child labour of children under 12 in all industries and categories will be eliminated;

- 1995: \* Eliminate child labour in fireworks industry.  
\* Withdraw children under 12 years from match industry.  
\* Eliminate bonded child labour in beedi industry.  
\* Withdraw children 10 years and under in all categories.
- 1998 \* Eliminate child labour in Match industry.  
\* Withdraw children under 12 in all categories (UPE goal).  
\* Eliminate all bonded child labour.
- 2000: Eliminate child labour in hazardous industries.

### **CURRENT STATUS:**

While the exact scale of child labour is not known, that it is extensive in some areas/industries (match, hosiery and beedi) is well known. It is also primarily a problem among girls.

Preliminary findings of an on-going survey in 3 districts of the match belt and feeder blocks indicate that the number may be even higher than the estimated range of 45,000 to 80,000.

Bonded child labour is found in varying degrees in all the industries employing children and domestically as maid servants.

### **ACTIONS:**

1. Situation analysis of the extend of child labour in the hazardous industries and to identify industries and areas with bonded labour throughout the state (to be completed by mid-1994)
2. Introduction of an integrated and multi-sectoral approach which addresses the problem from different dimensions for each hazardous industry; i.e., raising adult income levels, rural and agricultural development in drought prone areas, spreading of selected industries to alleviate concentration of labour demand, formation of workers cooperatives and unions etc.

3. Strong enforcement of the Child Labour Act (1986):
  - \* State Rules under the Act will be immediately framed.
  - \* Enforcement Machinery will be strengthened in child labour intensive areas.
  - \* Special Courts will be established in child labour intensive areas with special public prosecutors.
  - \* Designation of a panel of Medical Officer for certification of proof of age.
4. Link-up with compulsory primary education with common communication and social mobilisation activities.
5. Enlisting the cooperation and partnership of industrialists, union owners' associations and trade unions and working in close collaboration with non governmental organisation.
6. Minimum wages to be increased in selected industries and Government Schemes to be targeted to child labour families.
7. Shifts and flexible timings/calendar for schools to be introduced in child labour intensive areas.
8. Consumption credit facilities to be made available for parents to stem bonding of children.
9. Counselling and support systems for parents through NGOs, teachers and field functionaries to dissuade them from bonding their children.
10. Strict and immediate action by Revenue officials, police and other authorities to charge cases against employers and parents for bonding children.



## POINT TWELVE

### POPULARISING OF GIRL CHILD PROTECTION SCHEME AND IMPROVE THE STATUS OF THE GIRL CHILD.

- A. IMPROVEMENTS TO GIRL CHILD PROTECTION SCHEME
- B. IMPROVE STATUS OF GIRL CHILDREN.

#### A. IMPROVEMENTS TO GIRL CHILD PROTECTION SCHEME.

*GOAL:* To remove all obstacles for smooth implementation of puratchi Thalaivi Dr. Jayalalitha scheme for the girl child, and make it more attractive.

#### B. IMPROVE STATUS OF GIRL CHILDREN

*GOAL:* Improve status of girl children and women and achieve equal sex ratio.

- 1995: Arrest the declining trend in sex ratio.
- 1998: Reverse the trend in sex ratio.
- 2000: Achieve equal sex ratio.

#### *CURRENT STATUS:*

The sex ratio in Tamil Nadu has been declining steadily from 1050 in 1901 to 972 in 1991. Female infant mortality rate is higher than the male IMR, which is a reversal of the situation in 1980. Other indicators of gender disparities in the state include:

- \* Literacy - Male/female: 74.88% / 52.29%
- \* Primary School Drop-out - Male/Female: 17.1% / 19.6%
- \* Secondary School Drop-out Male/Female: 34.7% / 43.5%
- \* Agriculture wage - Male/Female : Rs.10/ Rs.8 per day
- \* Members of Legislative Assembly - Male/Female: 234/30.
- \* Women are more malnourished and anaemic
- \* Women are married off early at risk of death and illness due to too early and too frequent pregnancy and childbirths

- \* Women are ill treated and abused if dowry is not paid
- \* Because of poor education and low awareness, employment opportunities are low
- \* Thus, having had a life of deprivation and abuse, the older woman in turn deprives her own daughter and daughter-in-law.

These indicators reflect the fundamental preference for a male child & a belief that girls are more an economic and social liability than a value. The worst manifestation of this problem is female infanticide and foeticide, prevalent in several districts.

## **ACTIONS:**

1. Awareness creation and social mobilisation for improving the status of girls, value of basic education, evils of child labour, early marriage and pregnancies.
2. Removing gender disparities in Health and Nutrition care and Education and achieving Universal Primary Education and Literacy for women.
3. Legislation and strict enforcement of existing laws relating to girls and women including enforcement of compulsory birth and death registration, registration of marriages and amendment and enforcement of the Dowry Prohibition Act.
4. Economic development programmes for women and skill development for adolescent girls.
5. Strong advocacy through all public information channels for the girl child.
6. Special incentives as short term measures to ensure survival of female children.
7. Ensure availability of sex aggregated data in all sectors to monitor disparity reduction progress.
8. Provision of vocational skills and self-employment opportunities for drop-out adolescent girls.
9. Provisions of creches and balwadis near primary schools to relieve girls of child care and allow school attendance.
10. The Government will rededicate all development programme to improve the status of girls and women.

## **POINT THIRTEEN**

### **ERADICATION OF THE SOCIAL EVIL OF FEMALE INFANTICIDE IN TAMIL NADU**

*GOAL:* Female infanticide in Tamil Nadu will be eliminated

1995: Mapping of at risk areas and groups and simultaneous efforts to reduce female infanticide.

2000: Total elimination of female infanticide.

#### ***CURRENT STATUS:***

Patriarchal family system that has existed for many centuries in Tamil Nadu along with special rights of male child for family property and religious rites has resulted in a strong male preference in many communities. This coupled with dowry system and low status of girls in the society has led to problem of female infanticide in many parts of Tamil Nadu. The female infanticide in recent time has attracted the attention of NGOs as well as state government. Sex ratio in some villages in salem (1991 census) has been found to be as low as 930 as against 974 for the whole of Tamil Nadu. A study conducted in Salem 5 blocks reveled that over 2 years, out of 1200 infant deaths, nearly 45% were due to infanticide.

Government introduced the cradle scheme as an immediate short term measure to ensure survival of girl children born in blocks identified as high risk areas.

#### ***ACTIONS:***

1. Qualitative study to assess the situation in certain selected blocks.
2. Awareness creation and social mobilisation to eliminate social practices such as dowry and to eliminate female infanticide.
3. Ensure registration of pregnancies, births and all infant deaths.
4. Promote institutional delivery and intensify family planning measures.
5. Identify and target high risk mothers (with 2 or more girl children) for close peri-natal care and follow-up.



6. Enforce ban on 'sex identification' of foetus.
7. Awareness creation for new Government schemes for the girl children.
8. Half of IRDP loans to be given to women with special emphasis to cover "high risk" groups and blocks with adverse sex ratio and other gender sensitive indicators.

## POINT FOURTEEN

### PREVENTION OF CHILDHOOD DISABILITY AND EARLY DETECTION FOR REHABILITATION

**GOAL:** By 2000 AD, Childhood Disability will be prevented or detected early for rehabilitation within the community.

1995: Community-based prevention, early detection and rehabilitation coverage in 5 districts.

1998: Extension to 15 districts.

2000: Coverage in the whole state.

#### **CURRENT STATUS:**

Based on sample surveys, the number of disabled children (0-14 years) is modestly estimated to be 2.75 lakhs with the following breakdown:

- Visually handicapped	:	53,000
- Hearing handicapped	:	56,000
- Locomotor handicapped	:	162,000
- Mentally retarded & others	:	4,000

The present coverage is limited and institution based rehabilitation which is high-cost, benefitting only a few.

#### **ACTIONS:**

1. Services for prevention, early detection and rehabilitation of disabled children will be provided through an integrated Community-Based Rehabilitation approach strengthening efforts by NGOs and linking with government infrastructure and network.
2. All ICDS/TNIP workers and village Health Nurses and Traditional Birth Attendants will be trained in early detection and simple early stimulation techniques.
3. Simplified techniques will be developed for screening of new-borns at all maternity taluk and district hospitals.
4. Existing facilities and assistance will be extended for greater coverage through establishment of early detection institutions, genetic laboratory, regular supply of aids and appliances, etc.

5. Legislation for protection and integration of the disabled will be prepared.
6. Registration of disabled children will be made legislated.
7. Barrier-free environment will be promoted for disabled persons.
8. Eye donation will be popularised.
9. Communication through media and field functionaries for increased awareness of:
  - a. Risks involved in having children when maternal age is below 18 and above 30 years and in consanguineous marriages, especially in families with persons born with disability.
  - b. Care during pregnancy against accidents and communicable diseases and avoidance of smoking, alcohol, X-ray, heavy work and non-prescribed medication.
  - c. Child care to avoid accidents.
  - d. The disabled for better acceptance and integration into society.



## **POINT FIFTEEN**

### **CHILD SURVIVAL: EARLY IDENTIFICATION OF CONGENITAL HEART DISEASE AND FREE OPEN HEART SURGERIES FOR CHILDREN.**

**GOAL:** To be the first state to eliminate cardiac disorders in children

#### ***CURRENT STATUS:***

Every year, hundreds of young children die of congenital heart diseases in Tamil Nadu. In a majority of the cases, the birth defects cause heart ailments and only a limited number of children were affected by acquired heart ailments and by accidents. Most parents seek the help of private practitioners, which they may not be able to afford. The facilities and trained surgeons for performing open heart surgeries are available only in certain Government hospitals.

#### ***ACTIONS:***

1. To organise intensive surgical programme for the correction of the birth defects in the hearts as well as acquired heart diseases.
2. Strengthening infrastructures for cardio-thoracic surgery for children in all District Headquarter Hospitals.
3. Developing cardio-thoracic rehabilitation units in Government medical teaching institutions.
4. Provide barrier-free environment for the disabled children suffering from heart diseases.

## GENERAL ISSUES

The 15-point programme will give special attention to the needs of children who are most deprived and most in need of protection. These include the girl child, children of the urban poor and those working in hazardous industries.

In order to ensure that the 15 point programme is implemented effectively, special mechanisms will be introduced to implement and monitor progress. These include:

- A. Focussing on the most disadvantaged and vulnerable groups, especially children of the urban poor.
  - B. Establishment of a high level Committee and a Research and Monitoring Cell for the programmes of children.
  - C. Child Welfare Centres to be made child and women's Welfare Centres for the whole range of this 15-point programme.
- A. The children of the urban poor are especially vulnerable to poor health and nutrition from the deplorable slum environment. Children of pavement dwellers and street children are also vulnerable to abuse and crime.

All Schemes and projects in urban areas to be targeted to children most in need for their health, nutrition, education, shelter, protection, drinking water and sanitation.

Seven million people, 10% of the state population, are estimated to be living in poverty in urban areas. The five Metropolitan Cities contain almost half the state's urban population and have the most acute urban poverty conditions. Madras alone holds almost 30% of the urban population, with over 40% urban poor. *Actions will include:*

1. Each major city and large town will prepare special plans to focus services for the poorest of the poor.
2. Identify and map all locations/areas where the poorest population groups are found and assess the status of children and women in terms of health, nutrition and education and access to basic facilities and target basic services.
3. A Health Identity card system to be developed for families and children living on the streets for special out-reach services by IPV and other municipal health services.
4. Special efforts to be made to enrol all children in primary school or non-formal education centres and all schools and noon meal

and child welfare centres will be made available for evening NFE or coaching classes.

5. Shelter, drinking water supply and environmental sanitation facilities will be targeted to areas most in need.
6. Night shelters and Children's Assistance Bureaux will be opened in all the municipalities and corporations in collaboration with Non-governmental organisations for protection and improved services for street children.

3. Tamil Nadu Government will constitute a high level committee to review progress and establish a Cell for information generation, research and evaluation of programme.

Many Departments have vertical programmes for children and some data are available on children. There is an urgent need to collect and collate this information for analysis and further research. The needs of special categories of children such as the girl child, children of the urban poor and children in especially difficult circumstances also need inter-sectoral inputs which require monitoring of progress by a high level committee.

1. The Government will constitute a Cell with the objective of promoting research, monitoring and evaluation of programmes for children.
2. The Cell will generate and disseminate information needed for planning area-specific interventions by developing child specific and gender specific indicators at sub block level.
3. The Cell will identify areas requiring research into the extent of problems relating to children, adolescent girls and women as well as operations research in service delivery in social sectors.
4. The Cell will monitor and evaluate the scheme for children.

The Community Nutrition Centre activities under TINP and the Integrated Child Development services are carried out from the child Welfare Centres. With better scheduling, these centres can serve other development activities, especially for adolescent girls and women who have no meeting place for themselves. Actions will include:

1. Provide electricity supply and one bulb in each centre so that the infrastructure can be used for other development activities in the evening.



2. Conduct functional literacy classes in the child welfare center.
3. Provide for recreational activities for adolescent girls.
4. Conduct meetings for the community groups and health and nutrition demonstration sessions, and for socio-economic programmes.

Abstracted from an Hand out by TAMIL NADU GOVERNMENT ON

*"Dr. J. JAYALALITHA  
15-POINT PROGRAMME*

## *Part 3*

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*Readings on community Involvement in  
Health and Development of Women and  
Children*

*for Participants of 3rd Conference  
of SEARB Hosted by Tamil Nadu Chapter*





# 1. PARTNERS IN INDIA LIMITED

I have said it often and I repeat it here that in the implementation of the Five Year Plan, our approach must be to produce a sensation of partnership with the man in the village. The Five Year Plan of India is a people's plan, and in its implementation a feeling should be generated among the people so that each man, woman and child in India became as were, a "Partner in India Ltd." jointly engaged in the great task of building a new India.

This aspect should be constantly kept in view in the implementation of the plan as democracy could not function Governmentally alone.

JAWAHAR LAL NEHRU

7-OCT 1953

NATIONAL DEVELOPMENT COUNCIL, INDIA.

## 2. MAN: THE ULTIMATE OBJECTIVE

SHRI JAWAHARLAL NEHRU

It all depends on how you and I and all of us approach the question. Is it just another of our many schemes-good schemes, no doubt-in which we do our day's work and leave the rest to chance or is it something more than that? Is it something which you will direct from above as an administrator, as a central committee or as the Planning Commission and so on or is it something which will enable you to unleash forces from below among our people to do the work? Forces unleashed without definite aims and without proper coordination sometimes yield good results and sometimes bad. A good lead and a good organisation from the top is obviously necessary and essential yet it may be completely useless unless the forces from below are released.

If we act too much from the top without adequate foundations and without the intimate relation with the lower rungs, we can hardly achieve any good results. So the problem becomes one of how to bring about a union of these two elements.

Obviously, it is necessary to plan, to direct, to organise and to co-ordinate but it is even more necessary to create conditions in which a spontaneous growth from below is possible. By the term 'top' I do not mean that some people are superior; I mean those who guide, the organisers; and by 'others' I mean the millions who will participate in the work. In fact, even the initiative for community projects should come, wherever possible, from the people who are most affected by them.

I think the people themselves should be given the opportunity to think about what is good for them and thus they will affect our thinking as we affect their thinking. In this way, something much more living and integrated will be produced, something in which there is a sense of intimate partnership-intimate partnership not in the doing of the job but in the making of the job and in the thinking of the job. It is true that those of us or those of you who are more trained who have given more thought to the problems and might be considered, to some extent, especially suited to that kind of work are better qualified for thinking and giving the lead at the same time, it is equally true that unless those who must not be specialists but for whom you are working and who ultimately are supposed to work for themselves, feel that mental urge, that impact of the creative spirit within them to think and act, they will not work in the way that we all want them to work..

*(Inaugural speech at the First Development commissioner's Conference, Delhi, May 7, 1952.)*

### 3. A GRAND ALLIANCE

*Dr. Hiroshi Nakajima*

1. People are the true measure of the success of policies and programmes. At the same time, people are the determinants of success. Experience teaches us that, whether in the most sophisticated cities or in the remote villages, when people act with determination and understanding in pursuit of goals they deem essential, they achieve success.

2. So it is appropriate that we deal with the concept of community participation or involvement. It means much more than merely complying with medical prescriptions or contributing labour or money to health plans that others have already judged appropriate for the people. Expressed simply community participation is a grand alliance between people, policy makers and health workers for a common purpose.

3. It is imperative that this alliance should be democratic and not manipulative. If they are given the right and responsibility to participate and are appropriately supported, people have the wisdom, the ability and the will to deal with their own development. The challenge to policy makers and health workers is to get the best out of the "lay health resource" that people represent. Ordinary men and women are the most abundant, most effective and most economical tool for meeting health needs. For example, it has been estimated that well over half of all health care is self-care or care provided by the family.

4. Achieving community participation is neither cheap nor easy. It requires a long-term investment in training and reorientation. Sometimes social and cultural values or beliefs interfere, sometimes bureaucracy and excessive centralization make it hard for the community to see what is expected of it.

5. But these difficulties are surmountable, and the results are worth the effort and the time.

6. The second evaluation of implementation of the Global Strategy for Health for All by the Year 2000 shows that a large majority of Member States consider community involvement to be not only a political necessity but also an important and effective mechanism for planning, carrying out and evaluating health programmes. Many countries have participation mechanisms that are in full working order or are being further developed. Clear national policies and strategies: individuals and collective leadership: sustainable mechanisms, especially at the community level: and appropriate investment in time and money-these are some of the key factors for success.

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Director General World Health Organisation.



7. The great challenge we face is to establish and sustain systematic and routine practical measures which will bring about a democratic alliance between people and their health services. The growing world wide trend towards greater democracy and democratic values seems likely to bring this goal nearer.

*Abstracted from WORLD HEALTH, JUNE, 1992*

Health Education is a blend of information and education concerning health where people want to be healthy, know how to attain health, 'do' what they can, individually and collectively, to maintain health and seek help only when needed. This situation facilitates people to acquire the power to make decisions relating to their own health. It is a holistic educational approach with diverse objectives for disease control. The aim is not only individual behavioural changes but also organizational, economic and environmental concern for individual healthy life-styles, self-reliance and political action.

*-SEARB Bulletin Inaugural Issue*

## 4. HEALTH FOR ALL BY THE YEAR 2000

*H. Mahler*

(In an address delivered to three WHO's regional Committees-those for Africa, the Americas, and the western pacific-Dr.H.Mahler, then Director General of WHO outlined a broad course of action for individuals, communities, the health profession, health ministries, and WHO in order to bring about an acceptable level of health for everybody within 2000 A.D. An abstract of Dr Mahler's address is given below.)

What new ways are open to us? To answer this question we must consider health in the broader context of its contribution to social development. Too often is development equated with economic growth instead of with the progressive wellbeing of the people. To appreciate better what social development means it is useful to consider the meaning of social poverty. This is a pernicious combination of unemployment, poor housing, poor sanitation, malnutrition, ill health, social apathy, and lack of the will and the initiative to make changes for the better. These taken together create a vicious circle, and improvement of any of them could contribute to improvement of them all. We in the health sector have been guilty of confusing ends and means. It is now our duty to consider the benefits of all health action in terms of their social value rather than of their technical excellence. As a measure of social value I would still accept the utilitarian principle of the greatest happiness of the greatest number. The present system whereby conventional medical care benefits only a small group of privileged individuals in the main cities of most countries of the third world is the very antithesis of such a principle. It is a moral imperative of the new economic and social order that countries give health promotion its rightful place in all social and economic development.

Health improvement is a goal desired by all, and therefore less subject to political controversy than other social goals. Let us use it then as a lever for social development. To do so, we must realize that it will be necessary to relinquish many of our preconceived notions about the best ways of attaining health and to adopt approaches that are fundamentally different from those existing at present in most countries.

The most important criteria for appropriate ways of attaining health are their relevance to social progress and their economic feasibility.

The first principle in this new approach is that the distribution of health resources is as important as their quantity and quality. Resources are only too often allocated to central institutions, become proportionately scantier in direct

ratio to the distance from the main cities, and are non-existent or almost non-existent in rural areas. This maldistribution is not only spatial but also technical. The specialized curative services of the developed countries are only too often copied in the developing countries, leaving a scanty residue of resources for the promotion of environmental health and for primary health care. The time is now long overdue for a reduction of the growing disparity in the distribution of health resources not only between countries but also within countries. This redistribution must take account of population growth, which is often most rapid among the socially poor.

The second principle, namely that of social penetration, follows from the first. It is necessary to start by allocating resources to the social periphery and by a determined effort to ensure that socially peripheral populations participate fully in identifying their own health and other social problems and in seeking solutions for them. In their search they will no doubt encounter problems that require solutions beyond their ken. These are the problems that should concern the more central tiers of the health and other social systems as well as the political, administrative, and environmental authorities. This may sound like social planning in reverse. It is not. Social penetration has to be planned carefully from the centre, and I shall return to that.

Rural populations in developing countries are particularly underprivileged with respect to health care and social development in general, and even if they are not always aware of the possibility of making overall social and economic progress they are usually interested in improving their health. This interest should be fully mobilized; communities should be encouraged to take the initiative in developing simple health measures of their own, such as finding local solutions for drinking-water supplies and wastes disposal, the protection of houses against insects and rodents, and the provision of elementary health care. It should be possible to train locally recruited health agents, including wherever appropriate, traditional healers and midwives, to participate under suitable supervision in providing a minimal standard of care during the antepartum, intrapartum, and postpartum periods; in family planning; in infant and early childhood care; in nutritional guidance; in immunization against the major infectious diseases; in elementary curative care of all age groups for disease and injury; in basic sanitation with safe water; and in unsophisticated health education with respect to the prevailing health problems and methods of preventing and controlling them. The conditions for success are community enthusiasm and determination, a continuing process of motivating and training local health agents, and the full technical and moral support of the next tier up in the health service structure.



This reawakening of interest in health promotion could surely be harnessed to other aspects of social development. Discussions on nutrition could promote interest in local measures to increase food production. The protection of homes against disease vectors and the improvement of local wastes disposal measures could bring about a general improvement in the standard of cleanliness in the home and its surroundings. Education in health matters, such as basic sanitation, infant and child rearing, family planning, and nutrition, could give an impetus to individual and community self learning in general. There is ample evidence from a number of countries that the vicious circle of social poverty can be broken. Naturally, local patterns of community life would determine the manner of community participation, but the genuine participation of individuals, families, and community leaders covering the whole range of social and technical endeavour in the community cannot fail to lead to mass action for change.

I have referred to the need for peripheral health action to be supported by the next link up in the health system chain. This implies the adoption of a new role by more centrally placed health services in response to the needs of peripheral communities. Since the problems arising will be on a wider scale than the clinical problems of the seriously ill, the range of services provided will have to be correspondingly wider. They will include the continuing training and supervision of local health agents; the provision of guidance on simple sanitary measures; the dissemination of information on locally suitable disease control methods; logistical support for pesticides, medicines, and sanitary and medical equipment; and, of course, increased specialized clinical outpatient and inpatient care. They will also involve liaison and intervention with other sectors involved in social and economic development at the level concerned.

The functions of ministries of health will also have to be reviewed. A primary function of an invigorated ministry of health as I envisage it is that of leadership in introducing new ideas and policies-and not that of passive acceptance of conventional wisdom. I know that in many countries ministries of health do not have the formal power they require to ensure that adequate attention is paid to health development, but I am confident that if they dare to exhibit greater leadership in ideas this will lead to a strengthening of their influence on the establishment of social policies at the political level. Such leadership is required first and foremost to promote the confidence of the masses of the people. If political persuasiveness is to be applied to the attainment of social development it has to be fully backed by carefully defined policy and by soundly formulated plans and programmes. These are highly important functions, much more important than the routine administration of medical instruments that absorbs so much of energy of ministries of health in

so many countries. Their energy would be much more usefully spent identifying major health problems and on determining national health policies of the type I have tried to outline. Policies such as these are based on interlinked process-local needs giving rise to central responses and social needs giving rise to technical responses. It may sound paradoxical, but the implementation of such policies, which are based on peripheral social pressures and participation, requires careful central planning and support. It is necessary to set in motion and maintain the continuing process of planning, implementing, monitoring, controlling, evaluation, and replanning. Strategic planning is required to select priority programmes from among alternatives and operational planning to formulate the programmes it has been decided to implement. Such a national health planning process has become known as country health programming, which, like all other components in health planning, must be a continuing process. Its methodology has been kept as simple as possible, and its ultimate aim is to develop your capacity with your countries to clarify for yourselves the reasons for your health underdevelopment and, by yourselves through a process that is both rational and consonant with your culture, to decide on the most appropriate policies and programmes for developing the health of all your people.

To be effective, planning by ministries of health must therefore transcend the limitations of medical technocracy and become integrated into the mainstream of political decision-making activity. To this end, in many countries it will be necessary to create within ministries of health permanent mechanisms at the highest level for the identification of problems and the definition of policy, as well as for the formulation, management, and evaluation of health development programmes. Close contact will have to be maintained between ministries of health and central planning ministries where these exist, as well as with all other ministries and other ministries and authorities dealing with social and economic development. These, and other contacts, such as with universities, research institutions, and teaching hospitals, should be used to ensure that bilateral and multilateral cooperation for health is channelled into programmes that conform to the country's priority health needs in such a way as to promote national initiative rather than to smother it.

The mobilization of public and professional opinion and support for health development programmes is a particularly important function of a vigorous ministry of health.

*Abstracted from: WHO chronicle, 29:457-461 (1976)*



## 5. COMMUNITY INVOLVEMENT: NEW APPROACHES

*O. Adeniyi-Jones*

1. From time immemorial communities have organized themselves with varying degrees of sophistication to provide for the promotion of health and the prevention and treatment of diseases and disability, and to ensure the wellbeing of individuals as well as of the community as a whole. The extent to which they succeeded in their endeavours depended on the extent to which the services provided were within the reach of the majority of the population in a form that they could accept and use. This in turn depended on the extent to which the professional cadres responsible for the services were able and willing to deal with the most serious prevailing diseases, deficiencies, and harmful environmental conditions in a manner that could be understood by the people and that fitted in with their own attitudes and beliefs. To maintain health therefore requires the active and continuing participation of the individual and the community to which he belongs in order to ensure the development of good personal and community attitudes and behaviour patterns.

2. The services do not cover the whole population; there are marked differences in health status between people in different countries as well as between different groups in the same country; the cost of health services is rising without much improvement in their quality; and the public feels that most of the time medical and health work is directed towards satisfying the wishes of the medical profession rather than those of members of the community.

3. Although lack of public satisfaction is placed last on the above list, it is really the most crucial and significant factor.

4. The physician, and to a considerable extent every other health professional, is placed in an exalted position as the authority and repository of knowledge on health matters. The public tend to depend on him entirely for their health care. Under such conditions, the professional health worker has to make a special effort to appreciate the fact that he should try to satisfy the wants of the public and to involve lay members of the community in determining health objectives, strategies, and service patterns.

### **Community involvement**

5. Community involvement in health care means more than public participation in carrying out clean-up campaigns or in constructing wells, latrines, and health centres. It means sharing the responsibility and participating actively in planning and organizing health services. It also includes the proper



utilization of these services by the community. This approach implies that health problems cannot be solved by concentrating only on health programmes to the exclusion of problems in the socioeconomic field.

6. "Perhaps the most rational starting-point for a consideration of new approaches to effective community participation is a realization of the fact that the individual family and community are in fact already involved and already participate". It is their health and well being that are being discussed. It is their attitudes, habits or actions of the individual or of the family that promote or endanger their health. It is the individual who has to agree to be immunised or to accept and carry out specific disease and accident prevention measures. He has to recognize departures from normal health and present himself for medical care. Then he has to accept the treatment given and carry out any supplementary aftercare or rehabilitation measures including those for the prevention of relapse or of the spread of the disease to others. This sequence of events occurs even in the most simple societies. The difference between developed and developing countries (and between the privileged and underprivileged groups in developing countries) is the extent to which the former rely on, and have at their disposal, scientific measures, the latter having very limited facilities at their disposal and tending to rely on unscientific measures.

7. The next stage in the evolution of new patterns of health services based on active community participation is to consider the mother, housewife, or household head as the real frontline family health worker. This is the role played by mothers in developed and developing societies. The aim should be to equip them to play this role more effectively with the collaboration of those health workers on whom they would normally call for additional help, i.e., the traditional healer, herbalist, birth attendant, nurse, medical assistant, or physician. Thus the local community organization will consist of all the mothers and health workers in very small communities, or their representatives in larger ones, plus such representatives from other fields like administration, education and agriculture as may exist. Such an organization would include representatives of, and be in turn represented on, similar organizations, at district, provincial, and central levels, according to the administrative system in force. It would be responsible for deciding on local health priorities, for planning and organizing the method of work, the level of remuneration, and the selection of and training arrangements for such additional community health workers as are deemed appropriate, and for organizing self-help projects in relation to productivity, water supply, transport, housing accommodation, and education as well as health.

8. This approach would be based on the following general principles for ensuring simple, integrated, good health care at the community level (Primary

health care) which were recommended in a report submitted by the Director-General to the Twenty-eighth World Health Assembly:

(a) Primary health care should be shaped around the life patterns of the population it should serve and should meet the needs of the community.

(b) Primary health care should be an integral part of the national health system and other echelons of services should be designed in support of the needs of the peripheral level, especially as this pertains to technical supply, supervisory and referral support.

(c) Primary health care activities should be fully integrated with the activities of the other sectors involved in community development (agriculture, education, public works, housing and communications).

(d) The local population should be actively involved in the formulation and implementation of health care activities so that health care can be brought into line with local needs and priorities. Decisions upon what are the community needs requiring solution should be based upon a continuing dialogue between the people and the services.

(e) Health care offered should place a maximum reliance on available community resources, especially those which have hitherto remained untapped, and should remain within the stringent cost limitations that are present in each country.

(f) Primary health care should use an integrated approach of preventive, promotive, curative and rehabilitative services for the individual, family and community. The balance between these services should vary according to community needs and may well change over time.

(g) The majority of health interventions should be undertaken at the most peripheral practicable level of the health services by workers most suitably trained for performing these activities.

9. Principle (b) would call for the special representation of peripheral communities at the provincial and central levels where national health problems are being identified and policies formulated to resolve them. They would have to stress the following objectives.

- to reorientate and extend the existing health services so as to establish an integrated and comprehensive community approach at all levels.

- to ensure that the basic training of physicians, nurses, and auxiliary personnel is community-oriented, with emphasis on training for service.

- to encourage the recognition, utilization, and amelioration of useful traditional medical practices as an example of the hitherto untapped community resources available (principle (e)).

*Abstracted from WHO Chronicle, 30:8-10, 1976*



## **6.WOMEN IN HEALTH AND DEVELOPMENT:**

Women's health and involvement in health care are essential keys to health for everyone. That is because, quite aside from their own special health problems and the major challenges they face during pregnancy and childbirth, women customarily do most of the caring for their families. If they are ignorant, malnourished, or overworked, the health of their families as well as their own health will suffer. This is especially true for the many millions of women who confront illiteracy, poverty, poor sanitation, and medical facilities that are inadequate, unaffordable, or hard to reach.

What this means is that if the campaign for health for all is to succeed, women's health-as well as their roles in health activities-must be upgraded. And since women's health concerns are often quite distinct from those of men, it is proved worth devising a plan to address women's special needs. Women's health depends on broad considerations beyond medicine. Among other things, it depends upon women's employment, education, social status, and accepted roles. Ultimately, it may even depend upon their equitable access to economic resources and political power.

### **Social circumstances affecting health:**

The most obvious social circumstance affecting women's health is their low status. It is an incontrovertible fact of life that the socioeconomic status of women is generally inferior to that of men. This is reflected in many things- the tendency to prefer boy babies to girl babies, to educate boys better than girls, to assign women menial tasks, to pay working women less than men, to give relatively low prestige to such women's jobs as nursing and secretarial work, and to place few women in decision-making posts.

Of course, the extent to which women are subordinated differs greatly from one place to another. But there is virtually nowhere that such subordination fails to leave its mark on health. In the poor rural areas of developing societies, women suffer an undue share of illiteracy, overwork, and malnutrition. In the prosperous urban communities of developed countries, multitudes of single women with children maintain themselves at low- paid jobs while simultaneously trying to raise a family. The actual difficulties faced in each case are very different; but the overall effects are so marked as to cast doubt on whether real progress in women's health can be sustained unless women's status changes.



## Reproduction

One particular circumstance that confirms the low status of women is the sexual double standard that makes them mainly responsible for the reproductive process while denying them the right to control it. This standard, interwoven with sensitive and complex cultural values, emerges time and again—to afflict a girl denied information about how to regulate fertility; or a woman who dies of an illegal abortion; or a wife who continues bearing children she does not want because her husband insists on it, or because she (not he) fails to take the right precautions, or because religious, moral, or cultural values intervene.

The point is not that some particular act to control reproduction is necessarily right in any given case. The point is that women are denied control over their own bodies for any of various “higher” reasons, and so denied the freedom to do what they think best. This is all the more regrettable because most fertility control measures are simple enough to be provided by almost any health care centre.

Just as women should be able to control their own fertility, so should they be able to avoid most disease-imposed sterility. This means that more steps should be taken to treat women with genitourinary infections.

Aside from the short-term health issues involved, health and social welfare would seem better served over the long term if women, together with their husbands, could decide when to have children rather than leaving their childbearing to chance. The need is not to reduce or increase the number of children, but rather to space the births in a manner calculated to improve the family’s health and quality of life.

## Education

Another critically important circumstance that puts women at a disadvantage is inferior education. The problem is especially subtle and pervasive because education is considered preparation for leaving home, while women’s traditional “place” is in the home. Therefore, since women theoretically have a “refuge” not available to men they are presumed to need less education.

This logic cuts across all social strata. It explains why jungle Indian families send mostly boy children to Mission schools, why middle-class families send more boys than girls to college, and why girls and young women generally feel less obliged to pursue an education having absorbed the cultural lore that says it is not needed.

In fact, it is badly needed. Consider education about health matters alone. By preparing women to read, write, learn about health, and care effectively for

themselves and their families, women's education makes a vital contribution to family welfare. At a very basic level, illiterate women often find it hard to absorb modern lessons about sanitation, infection, disease, nutrition, fertility regulation, prenatal and postpartum care, child-raising and a multitude of other matters important to good health. Women with no formal education are more apt to embrace the traditional status quo, less apt to adopt new practices that could improve family health and welfare. And women of all strata whose education has been slighted are relatively ill prepared to become good health care providers, or pursue careers on an equal basis with men, or reach decision-making levels where they stand a chance of influencing official health policies. In this way women's inferior education cuts back everywhere on their chance for contributing to their own health and that of others.

### **Work hazards, work-load, and wages:**

Another condition that greatly influences women's health is their employment. Among other things, women are exposed to a host of occupational health hazards. Sometimes occupational circumstances threaten the health of women more than men, and sometimes they endanger unborn children. For these reasons it is necessary to take the special needs of women explicitly into account in gauging occupational hazards, rather than assume that the risks for men and women will be the same.

Beyond this, however, lies a far more profound problem. For a host of reasons, including established customs and poor education, women everywhere tend to be overworked, underpaid, and denied access to high-income, high-prestige positions. Like inferior education, this circumstance directly affects women's health, their ability to care for their families, and their capacity to influence the male-oriented traditions, doctrines and policies responsible for this state of affairs.

The most obvious damage is suffered by those worst-prepared to cope with the poverty-stricken women. In the rural areas, women constitute well over half of the agricultural labour force; and in poor urban zones many are employed as street vendors, or domestic servants, factory workers. That being the case, the fact that these women generally remain responsible for child-rearing and household chores means they must deal with more than just poverty, ignorance and poor hygiene; they must also cope with over-work and fatigue, and must be prepared to find themselves continually short of time.

Women are generally responsible for children's health. So women will be asked to participate in many different ways-to procure and prepare recommended foods, to make up and administer oral rehydration solutions, to care

the fuel and water needed for such purposes, to spend more time at home gardening or at earning the money needed for the right foods, to provide the volunteer labour needed for promoting better health in the community, and to make trips to the local clinic for prenatal care, periodic babyweighing, children's immunizations, and so forth. As a WHO conference on women and family health pointed out in 1978, "in the existing definition of primary care, and in the way women's roles were described, there was the danger that women's already heavy workload would be increased and that the 'voluntary' nature of their traditional work in health would be exploited". Therefore, the health for all effort, besides being responsible for promoting everyone's health, also bears responsibility for not adding unnecessarily to women's burdens and for ensuring that the time women invest in health work provides worth while.

But overwork is only part of the problem. For it is also true that most women who are literate, educated, and able to procure reasonable jobs tend to become secretaries or enter "women's" professions such as nursing that offer relatively low wages and prestige. This means that many women- especially those who are single and trying to raise families- are hard-pressed to make ends meet.

*Asbtracted from: WHO Chronicle, 38 (6): 249-255(1984).*



# 7. HUMAN DEVELOPMENT AND HEALTH

*Halfdan Mahler*

It is people who matter; it is they who can make or break their own development and that of the community and, ultimately, the world.

The last word has not been spoken on the world and the world's resources. Too many factors are involved to permit the question to be settled easily, and too many conclusions have been reached through limited perspectives. A vital factor in the equation, all too often forgotten, is people's energy. People's creativity and ingenuity can outweigh theoretical calculations, just as their apathy can turn planners' dreams into implementers' nightmares. Indeed social apathy is one of the components of that pernicious combination of unemployment, scarcity of material goods, low level of education, primitive housing, poor sanitation, malnutrition, and disease that makes up the poverty and underdevelopment in which some 1000 million people are still trapped. Healthy people can be a powerful lever for breaking out of that vicious circle; unhealthy people will only perpetuate it. So the balance between population size and world resources is not just a matter of quantity; it is a matter of quality.

A historical glance at the improvement in quality of life in the industrial countries may provide pointers to ways of improving the quality of life in developing countries. Starting about a century ago, people in what are now the industrial countries awoke to the social potential of the industrial revolution no less than to its harmful consequences. Gradually, over time, they adopted political and social measures that led to better nutrition, more suitable housing, cleaner water, safer waste disposal, improved hygiene, more universal education, and healthier working conditions. Gradually, imperceptibly, infant mortality went down, life expectancy went up, and, fertility rates declined. And all that happened before the modern contraceptive era that began only a generation ago showing that political and social action, not to mention individual behaviour, is just as important as technical innovations for people's control over their fertility, their health, their well-being, and hence their development.

The developing countries cannot afford to wait one hundred years for all this to happen, considering the appalling rates of death in childbirth and infancy that prevail in some of them. Nor need they wait: an impressive range of technical measures is available now to promote and maintain health at an incredibly low cost. Among these are measures for maternal and child care,

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Director-General, WHO

including measures to permit the timing and spacing of childbearing in a way that is healthy for mothers, infants, and whole families in keeping with their cultural principles. Now that many such technologies are available, in addition to political and social measures, the historical process can be speeded up.

The process can be speeded up even more if people display the will to develop their own material, intellectual, and spiritual potential. And wise national policy implies consistent measures to help people do so. Past attempts, divorced from development, to force measures of fertility control on "populations" gave rise only to resentment, resistance, and rejection. If most governments have come to realize the likelihood of such reactions, surely we all must learn from recent history and join forces in genuine efforts at promoting human development.

WHO's strategy of health for all by the year 2000 through primary health care is precisely health as if people truly mattered, strategy in which people are both the subject and the object of their development. It goes far beyond the struggle to remain alive: health and development mean very much more than survival in misery. It is a strategy to support people in adopting those measures that made life progressively more pleasant for previous generations in the industrializing countries. It is a strategy to support people in taking action in their own ways in ways understandable and acceptable to them so that they can assume growing responsibility for determining their own health destiny and hence contributing to their socioeconomic destiny.

An important feature of the strategy is the care of families, and essential to that are respect for the status of women and the provision of maternal and child care including family planning. Family planning can indeed lead to striking improvements in the health and well-being of mothers and children and the whole family. In all societies it is the family in one form or another that is the central nucleus for people's lives, their development. In keeping with this, the health-for all strategy aims at ensuring that every child born is truly wanted and enjoys the best possible opportunity to grow into a healthy member of a decent and just society.



## 8. LEARNING ABOUT YOUR COMMUNITY

You may already know many things about your community, especially if it is a small one. But do you know enough about it? You will learn more talking in a systematic way with its leaders and other people. Do not ask many questions though; it is better to observe, listen and learn! Here are some of the things you should find out.

- \* How many people are there in the community, and how many of them are young, middle-aged, and old?
- \* How do people get food? How do they earn money? Are they farmers, workers, fishermen, cattle-farmers, estate workers, factory workers? How do they spend their free time?  
Do they work at night?
- \* Do children work? How many of the children attend school?
- \* Is the community poor? Is it becoming poorer or less poor? Is its standard of living higher or lower than the average for the country? Are there good markets, good roads? Is there clean water supply? Is there electricity, telephone service, a bus service?
- \* How do families live? What are the houses like? Do they have a system of sanitation? Are the houses clean and free of pests?
- \* Who makes decisions within the family? How many children are there in the average family? How are the children fed and how are they taught? What are the most common beliefs, values and traditions?
- \* What are the main health problems and what are their causes? Some causes of bad health are:
  - too many people living close together;
  - not enough water or the water is not safe;
  - not enough food of the right kind;
  - unclean houses in dirty surroundings;
  - no way to keep cool in the heat or to keep warm in the cold;
  - no latrines or the latrines are dirty;
  - no protection against insects that carry diseases;
  - the health centre is difficult to reach;
  - people cannot read and thus do not learn about health and healthy habits.

Talk to various groups and people: families or households (both rich and poor), those who make decisions for the community about the community and members of special groups. Try to find out:

- what part of their income do they spend on health?



- what community problems are they especially concerned about?
- what have they been doing about these problems?
- **what do they think can be done?**
- who are the leaders, or those who make the decisions for the community? They may be tribal leaders, religious leaders or political leaders. They are the ones who are most likely to help in improving health. Other people whose opinions and support are valued may include the elders, landowners, money-lenders or businessmen.

Find out how the community is organized and who runs its affairs.

**For example:**

- Which group makes decisions for all the people? Is it a development committee, a political body, or some other group?
- Does this group deal with all the affairs of the community? Or does it have subcommittees that look after different needs of the community, such as health, water supply and education?
- Is there a health committee? Who are its members and how are they chosen? What are their tasks? How often do they meet? Are all sections or groups in the community represented?
- What other groups are there? For example, a women's group or a farmers' cooperative.

If you are a schoolteacher, why not ask your students to do a community survey based on questions like these? Then you call a meeting of parents and ask the students to present their findings. May be a movement to improve health could be started?

### **Drawing a map of your area**

A map is a useful tool to study the health and sanitary situation in a community. If there is not already a good map of your area, ask other people (for example, the schoolteacher and schoolchildren) to help you to draw one. This map will show the rivers, schools, health centres, temples, roads, shops and other important places. Take the map to the community committee and place it where the people can see it.

As new information comes in, mark it on the map. For example, show the wells or houses that are not in good condition. Keep the map up-to-date. It will make it easier to detect some of the health problems, and also to show by how much community health improves from year to year.

*Source: WORLD HEALTH, JUNE 1992.*

## 9. COMMUNITY PARTICIPATION

The concept of community participation- that people must themselves be involved in improving their conditions through their individual and cooperative efforts - has become incorporated into the ideology of socio economic development. It is based on the recognition that governmental resources and powers are finite, that government programmes are often socially inappropriate, and that doing something for people is a less effective development strategy than enabling people to do more for themselves. The concept also enlarges the discussion about decentralization, taking it beyond the issue of reducing the powers of central government so as to increase those of local administrations, to include the question of how to enlist the talents and energies of the masses of the people in raising the level of community well-being.

There can be no universally applicable method of putting community participation into practice because the needs and possibilities for, and constraints on, community action differ so widely, depending on national politicoeconomic systems and socioeconomic status, on the location of the community (in an urban or rural area), and on the particular segment of a city population concerned. This approach must nevertheless be adopted everywhere if progress is to be made in improving the situation of the urban poor in developing countries.

Useful strategies are available, as a number of local experiments, and even a few national ones, have demonstrated in highly diverse social systems. In global terms, however, the approach is very much in the "research and development" stage, and some scepticism exists as to whether successes in some areas can be repeated elsewhere. Thus, the full potential of community involvement remains to be tapped. Apart from the strategies for mobilizing popular resources, some societies must deal with the more basic issues of the limits of the government's responsibilities, the reorientation of bureaucratic structures and personnel, the possibilities for interaction between community workers and organizations and specialized government agencies, and the reconciliation of individual liberty with the need to conserve the common resources of communities, ecosystems and the biosphere. At present, with renewed concern for the future of the global environment and the revitalization of democratic impulses in many regions of the world, both the uncertainties and the opportunities have increased.

*Source. WHO.TRS 807,1991.*

## **10. COMMUNITY INVOLVEMENT IN HEALTH DEVELOPMENT (CIH)**

Health development is not an isolated activity but one of several facets of development. It is thus impossible to dissociate health development from development in other sectors.

Over the past ten years or so, a rethinking of developing strategies has led to the emergence of participation as a central concept suggesting a new direction to develop people's talents and skills or enable them to play a central role in the development process. It is argued that development should be people centered and that emphasis should be placed on involving people in development processes as partners and not as passive bystanders. Across the various development sectors - agriculture, health, water supply, and resource conservation, for example - the active participation of the local population should be sought in order to ensure that programmes and projects are soundly based and enjoy public support.

In the health field there is widespread evidence that the majority of the world's people have no regular or dependable access to health services.

An essential ingredient of the worldwide strategy for health for all is the massive involvement of the public, not just in the support and operation of health services, but more importantly in the determination of health priorities and the allocation of scarce health resources permitting the development of health services that are people's services, responsive not only to people's needs in respect of health and development, and encompassing more than just services designed and maintained by health personnel or focussed solely on medical care. It could be argued that the fundamental obstacles to health for all lie outside the sphere of medical science, being created by the kind of economic and political conditions in which people have to gain their livelihood today.

### **What constitutes participation?**

An understanding of the meaning of participation in development is useful in any discussion of the concept of CIH. Participation defies any single attempt at interpretation.

It is now considered almost reactionary to propose a development strategy that is not participatory, and the major stages of the development process - research, planning, implementation, and evaluation - have all undergone reorientation with the aim of making them more participatory.



Basically, participation is interpreted in three different ways: as contribution, as organization, and as empowerment.

### **Participation as contribution**

Participation in development projects is most often seen as consisting of voluntary or other contributions by people to predetermined programmes and projects. Many projects in such areas as health, water supply, forestry, etc. stress the importance of such contributions as being implicit in participation and indeed fundamental to success. They may take the form of either material contributions or voluntary labour.

### **Participation as organization**

In all types of development actions, appropriate organizational structures are fundamental to participation. The type of organizational structure required is a matter best decided according to the national or local situation. Representation of the community's interests is far more important than the type of structure through which participation is effected.

### **Participation as empowerment**

The notion of participation as a means of empowering people has gained increasingly wide support; It is, difficult to define. Some see it as the development of skills and potential contribution to make to development; others see it as being more fundamental and essentially concerned with enabling people to decide upon and take the action that they believe is essential for their development.

### **Advantages of participation**

The following are among the more substantive arguments for the participation of the public in development projects:

**Coverage.** Most development projects reach only a limited, and usually privileged, number of people. Delivery services often have contact with only a small fraction of the population. Participation will extend this coverage, in that it will bring more people under the direct influence of development activities. Participation will increase the number of potential beneficiaries of development and could attract more public support for health and similar services.

**Efficiency.** With willing participation by all those concerned in planning, implementation, monitoring, and evaluation, there should be greater coordination of resources, activities, and efforts. This should reduce duplication of efforts and resources, as well as concentrate the action on fewer areas of work at any time.

**Effectiveness.** After there is agreement about priorities, those interested in working specifically in the relevant areas can pool efforts to determine goals, objectives, plans and strategies for action and give local efforts the benefit of their knowledge, skill, and resources.

**Equity.** By participating in development projects, community members can promote equity through sharing of responsibility, solidarity, serving those with the greatest risk, and seeking to promote better health for the hundreds of millions of people who still do not enjoy access to the necessary resources and services.

**Self-reliance.** Participation promotes self-awareness and confidence and causes people to examine their problems and to think positively about solutions. Participation at community level increases people's sense of control over issues that affect their lives, helps them to learn how to plan and implement activities, and, on a broader front, prepares them for participation at regional or even national level.

*Source WHO TRS 809, 199R1*

## 11. MAIN REASONS OF FAILURE OF CIH

There are four main reasons why many health development strategies have not had substantial impact in promoting CIH:

1. They have failed to encourage people to think and act for themselves and have largely let them depend on external sources for answers and direction.

2. They have not paid enough attention to the question of sustainability with the result that too often the health services established could not be maintained by local people. There has been inadequate training of local people as well as a reluctance to base health and development services on local resources and knowledge.

3. Although people have contributed their labour and other resources to health programmes, they have rarely been involved in their design or implementation. This has meant that local people have felt little direct commitment to health programmes and that the services offered have often borne little relation to actual local needs.

4. A conflict is liable to arise between medically directed needs, as determined by the health services, and health-related needs (e.g., housing, water, or transport), as determined by the people themselves. This conflict often results in an incompatibility between the two sets of needs and a lack of local concern for, or interest in, externally promoted health programmes.

Designed to counter the kinds of failure just noted, CIH has emerged over the past decade as a radically different strategy for health development.

*SOURCE: WHO - TRS - 809 - 1991*



## 12. FOUR BASIC CONDITIONS FOR COMMUNITY PARTICIPATION

1. The existence of Mutual trust between members of the community, members and their leaders and outside agencies co-operating with the community in the development of community based activities.
2. The community must be given the opportunity to participate.
3. The community must consider a programme worthwhile in that it provides something which they value.
4. The community has a strong sense of ownership and responsibility for a programme.

*-M. Johnstone,  
INDONESIA.*

### Meeting Global Health Challenges

Health Education is the combination of planned social actions and learning experience designed to enable people to gain control over the determinants of health and health behaviours and the conditions that affect their health status and the health status of others.

To ensure that the needs and interest of the target population remain central, members of that target population must be involved in the planning process.

The principles of participation assures that there is respect for people and a basis for pursuing mutual efforts and partnerships. In such a context, the educational exchange may be characterized as doing something 'with', rather than 'to', others.

*-IUHE, WHO & Centres for disease Control, USA.*

### 13. DETERMINANTS OF CIH

CIH cannot function in isolation. As a basic principle of health development, it will relate to, and be influenced by, the particular circumstances and characteristics of the setting or country in which it is practised. In particular it will be influenced by prevailing political and economic conditions. For example, a broad distinction can be drawn between two different situations in which CIH could be implemented:

- Where resources for health development may be relatively plentiful and where there is a degree of consumer choice in respect of both state and private services;
- Where resources for health development are usually scarce and where peoples' choice is limited by a lack of resources, so that there is greater dependence on state health services.

In any country, a number of critical factors will influence the implementation of CIH as part of the strategy for achieving health for all:

- \* Political commitment within the country to the concept of people's involvement. This will be particularly important at the local level where resistance from established interests will have the greatest impact. Political will and commitment are expressed not only in doctrines and proclamations but in the allocation of resources, new technologies, and the transfer of real power to communities.
- \* The reorientation of the formal health and development institutions within the country towards support for the devolution and delegation of bureaucratic authority down to the levels at which CIH will operate. A critical step will be the decentralization of health services and the corresponding strengthening of the local health services that will serve as the basis for CIH. The reorientation process will also encompass decision-making, budgeting and staffing in the health services-issues of vital importance to the creation of a bureaucratic climate favourable to CIH.
- \* The economic situation within the country, which will largely determine the emphasis given to health development and the resources available for it. In many a basic communities lack of economic resources makes the promotion of health development difficult. In others, health has a low priority and so fewer resources are made available to the health sector. The implementation of CIH requires specific resources - staff, logistic support, and teaching materials - and these may be difficult to obtain where health is not a priority.

The level of development of local structures and organizations, which can serve as a basis for CIH, as well as the availability in the community of the managerial and other skills needed to enable the population to play a greater role in health development. Where such structures and skills have already begun to emerge, CIH might have a better chance of making a fairly rapid impact.

*SOURCE : WHO TRS - 809, 1991.*



## 14. BASIC PRINCIPLES OF COMMUNITY INVOLVEMENT

Community involvement is a process in itself and needs to be developed over a period of time. Of particular importance is the recognition of a number of basic principles that guide CIH methodology. Such principles, which can be inferred from emerging practice, and particularly from practice in other sectors, could include the following:

- \* *Emphasis should be placed on the process of involvement* as opposed to immediate and quantitative impact on a particular health problem. Health projects seeking to involve people must be flexible and open to experiment, and not merely stick to rigidly determined project objectives.
- \* *There should be a balance between activities aimed at creating awareness and health care activities* in order to have a proper basis for people's continued involvement. Involvement is achieved by creating awareness of health issues and problems, and health care activities should not be allowed to stifle this process.
- \* *Build where possible on a local base* in order both to ensure a secure basis for future health development in the area and to minimize dependence on external agencies.

### **Direct participation** (the mobilization of community resources)

- \* Believe in people's ability to participate and respect traditional health beliefs and practices.
- \* Place your knowledge and technical skills at the disposal of the population and take a critical role in discussions of health problems.
- \* Base health programmes on community health diagnosis, made by the community itself with your help. Discuss the results and conclusions with the people.
- \* Preserve people's control over their own health services by introducing only such programmes as they can understand and control.
- \* Be democratic in running the health programme.

### **Social participation** (increasing community control of health programmes)

- \* Encourage and participate wholeheartedly in critical discussions of the perceived causes of health problems: traditional, biological, and especially social.

- \* Promote critical assessment of the existing health services in all their aspects: traditional, scientific, and managerial. Do not treat the health sector in isolation but in the context of the community's place in society.

These approaches should be seen as constituting the two extremes of a broad methodological spectrum. CIH must be the responsibility of somebody at the local level. CIH will not just materialize; it must be developed. The key person needs to be identified and then undergo a suitable period of training.

*SOURCE: WHO TRS 809, 1991.*

## 15. SPECTRUM OF CIH PROCESS

- *Isolation or ignorance:* Where communities have no access to the means of involvement, and do not even understand how they could become involved in promoting their own development.
- *Utilization:* Where community involvement is mainly limited to the receipt of the benefits of health development programmes and there is little active involvement in planning or implementations;
- *Resource contribution:* Where communities become more active, contributing both materially and through their labour to the health development programme and assuming some responsibility for its management.
- *Community control:* this is the ultimate stage, where initiatives for setting health priorities and for the planning, implementation, monitoring, and evolution of health programmes rest with the community, and external agencies (governmental and nongovernmental) support it in its controlling role.

SOURCE WHO TRS 809,1991



## 16. ROLE OF EDUCATIONAL PROCESS IN CIH

Participation is essentially an educational process and accordingly CIH must contain a strong education element. This can be one of two forms: *information*, in which local people are told of health programmes or projects and how they might get involved in them; or *awareness*, in which the emphasis is on creating an understanding of health problems and their causes as a basis for suggestions by local people of acceptable solutions. As a methodology, therefore, CIH is not just concerned with implementing a particular health programme but more, through a process of education, with creating a basis for people's sustained involvement.

*SOURCE WHO TRS 809, 1991*

### **Tuberculosis - A Neglected Health Crisis**

According to Dr Arata Kochi, Manager of the WHO Tuberculosis Programme, "tuberculosis is the world's most neglected health crisis. Past neglect of TB by governments in all regions, together with declining scientific interest in infectious diseases that seemed no longer important in the industrialized world, have led to little action on the TB epidemic by many of those responsible for safeguarding public health. How can we ignore a germ that already infects one in every three people on the planet?"

## 17. MECHANISMS FOR FACILITATING CIH.

The methodology employed for facilitating CIH will depend on the kind of mechanism that are available or could be introduced to facilitate the CIH process.

### **These might include:**

- various forms of communication used locally to transmit information and messages of common concern (community meetings, folk art, media);
- local groups representing people's interest;
- key individuals who may be relied upon to provide direction and leadership to others.
- demonstration of trust in the community by devolving some responsibilities to it;
- special recognition, in the form of an award, for the successful completion of a health programme.

The following have proved in practice to be among the more important mechanisms for facilitating CIH:

- \* **Village health committees** or similar bodies that can form the organizational basis for CIH. These committees can identify local needs in health, mobilize resources for health development, and implement and evaluate health projects. It appears, however, that village health committees are often stronger on paper than in reality, serving merely to facilitate the mobilization of support for health projects and not really providing a basis for the control of health development by the people.
- \* **Peripheral health workers or other individuals** (TBA, CNW, AWW, etc.,) who play a central role in linking the health service with local people and indigenous health knowledge and practices. These workers are not indigenous health knowledge and practices. These workers help allay people's suspicion of external projects.
- \* **Health campaigns** whereby a health issue is promoted at the regional or district level and people's interest aroused and nurtured to secure their future involvement. Teams are deployed throughout a region in a mass information operation and seek to involve people in the proposed health action.
- \* **Discussions and local meetings** at which people can play an active part in the analysis of health problems in their particular area. These should

not be a one-way process of information but a means of listening to people's opinions, their perception and understanding of health problems, and their ideas on possible solutions. Such discussions can lead to new insights into health problems, combining aspects of popular knowledge and of scientific and technical knowledge. A forum for open and equal discussion is a fundamental prerequisite of any process of CIH.

**Drama, dance, festivals, art, and song** are more innovative approaches that are now beginning to be recognized in the health sector. It is generally agreed that people tend to be bored by purely didactic lectures and talks, and are more receptive to narrative, dramatic, and musical forms of communication. Moreover, the latter are excellent means of building awareness. Mobilizing people for action, and generally getting people to reflect on particular issues. Further more, as people become involved, such mechanisms of communication help them to express their own ideas and feelings about a situation. Finally, indigenous forms of communication can have a unifying effect, helping to develop solidarity among a group of people over a matter of common concern.

*SOURCE: WHO TRS 809, 1991*



## 18. INTER SECTORAL COORDINATION AND CIH:

Improving the community's environment demands action in many sectors and by public, private and community bodies. One of government's responsibilities is to ensure coordination between those concerned, which can greatly enhance effectiveness and reduce cost.

The agenda of government administration, if centrally formulated, may often differ from that of the community, even when the administration's objectives are justifiable, if they are of little current interest to the community. Broad participation and negotiation are needed to ensure compatibility and to avoid conflicting agendas and competing group interest. External agencies can sometimes be helpful by playing the part of the "honest broker".

The "district team problem solving" approach has been used in some countries in order to promote community involvement and coordinate it with local government efforts in the provision of health and public services. The approach brings groups together to provide mutual assistance and generate ideas and plans of action, and as means of evaluating what is achieved. It is attractive to administrations as a model for joint action by government personnel and community members. Where political democracy is on the increase, greater use can be made of public hearings in assessing the environmental impact of development plans; these are often useful in furthering community education and developing political maturity.

*SOURCE WHO TRS 807-1991*

### **World Health Day 1994**

The World Health Day (7 April) theme for 1994 focusses attention on oral health, with the slogan: "Oral Health for a Health Life".

## 19. DOES THE COMMUNITY PARTICIPATE?

How can we find out to what extent there is community participation in health action, and how can it be stimulated and improved? A group could be created to evaluate the situation. It could consist of some health workers, representative from local voluntary organizations, women's groups and youth groups, and may be a teacher or other specially interested individuals. The purpose of the evaluation is not to report to some higher authority, but to provide information to the local community so that community participation could be improved. This is why it is important for the local people themselves to be responsible. The evaluating group should look into the following aspects of participation:

- \* What are the relations between the community and health workers? Do they meet regularly? Do they collaborate on specific Projects?
- \* Do the health workers agree to let the community decide on local matters such as the working hours of the health post?
- \* Is there a health council or other group that meets regularly, and which has well-defined responsibilities?
- \* Are people willing to participate? If not, why not? Are there different interest groups in the village which do not want to work together? Is there no perceptible interest for health matters in the village? Why?
- \* In what activities does the community participate - in planning and evaluation, in decision-making, in providing funds or voluntary labour, in contacting higher political and administrative authorities to obtain support?
- \* What have been the results of community participation? Have people become more aware of the importance of health? Are they more satisfied with the health care provided? Has it improved? Is health improving?

The findings should be written down and discussed. Hopefully, they will result in better collaboration between the health workers and the community. Things can always be improved!

## **20. AN APPROACH TO THE TRAINING OF SELECTED COMMUNITY MEMBERS FOR PARTICIPATION. (SRI LANKA CASE STUDY)**

1. A participatory training programme is conducted for small groups, not exceeding 20 or so participants, with trainee and trainer on an equal footing.
2. The starting-point is a collective look at, and analysis of the experience participants already have in working with their own communities.
3. The next step is to analyse the social realities of village life on the basis of participants own knowledge and experience.
4. This microanalysis is followed by a macroanalysis. Salient features of the national economy, politics, and society are brought into the discussion and where relevant, the operation of national and international forces is highlighted.
5. Next, the training programme goes into the field. Participants go to selected villages where they live in the community and study actual conditions.
6. While in the field, the trainees seek to mobilize people to carry out investigations and analyse their own situation.
7. While continuing their field work, trainees will regularly share experiences and reflect on them collectively. Their learning process thus takes the form of work in the field, followed by collective reflection and analysis which enable them to improve the quality of their work and gain a better understanding of it.



## 21. WOMEN SHOW THE WAY (IN D.P.R. KOREA-VILLAGE WOMEN'S CLUB-F.P. SERVICE - A CASE STUDY)

The planned parenthood Federation of Korea was asked to organize women's clubs in each of the 16,868 villages to generate the idea of involving women in decision-making in the family in contrast to the traditional male superiority in Korean families. During the first year, 17000 village clubs were formed and 27,292 clubs came into existence by the end of 1976. Each club had 10 to 15 members with the focus on family planning. Village clubs formed township groups and they in turn got together to form the country Federation of women's clubs. The Movement after 1979, became a truly dynamic activity with roots in the lives of people and propelled by the people. From being 'inside persons' in the family the women are now increasingly involved in decision-making on family matters and not least on sensitive family planning issues.

*Source: Unpublished WHO document on success stories by Ms. Leonor Zamora, WHO consultant.*

One of the most important factors affecting safe motherhood is the low status of women, who are neglected, suppressed, and ignored. Their health, education, and employment needs are given the lowest priority. They are forced to marry at a young age and are not permitted to be exposed to the modern means of contraception. As a result, they have to undergo the travails of constant motherhood, besides the drudgery of household chores. In the rural areas, women work in the fields along with men. They carry out the additional chores of carrying drinking water over long distances, caring and cooking for the family, and looking after the children. This situation has to be altered. Women must be given their due share in the economic life of the community.

**Begum Nusrat Bhutto,**  
**Pakistan**

## 22. STRENGTHENING COMMUNITY ACTION FOR IMPROVING ENVIRONMENTAL HEALTH IN URBAN AREAS.

Community organizations, in both developed and developing countries are defined as organizations or associations formed by groups within a particular community, e.g., associations of householders within a particular neighborhood or tenants' associations. Many examples of successful actions taken by such organizations (often in partnership with local nongovernmental organizations or government) have shown that community action can be an important part of more effective responses to current problems. Shared problems and common causes within a particular district often unite different populations and stimulate community action or organization. With appropriate help, such actions and organizations can participate effectively in addressing environmental health problems.

In virtually all developing countries the enormous burden of disease, disablement and premature death can be substantially reduced without the expenditure of vast sums of money. The sheer size and pervasiveness of urban health problems, the inadequacy of current institutions in addressing them, and the lack of resources to address them effectively through conventional curative services all suggest the need for new approaches to improve the environment for health. One such approach is through community organizations.

While many examples of successful community actions can be cited, there is still a need to greatly expand and multiply such actions, particularly in the urban areas of developing countries. The way to achieve this is through establishing and strengthening a viable partnership between government, nongovernmental organizations and community groups, which could be strengthened by the participation of professional and university groups. This partnership approach implies significant changes in attitude on the part of all those involved so as to create conditions of mutual respect, genuine consultation and constructive cooperation.

Initiatives for environmental improvement (including community participation) often originate with government-financed projects (so called "top-down" initiatives). An overriding objective of the partnership approach is to facilitate the organization of community groups and increase their environmental health needs and priorities, to make changes, and to mobilize the resources of the community, including its own talents, energy and initiatives in "bottom

up " actions. Such an approach is essential if poorer groups, whose environmental health needs are often unmet, are to be involved in the general political and social process. Sound community action requires participatory political structures, and government support for community organization and action is a way of fostering democracy at the grass roots.

Several decades' experience with externally funded development projects has also demonstrated that the methods whereby information and decisions on environmental improvement are shared with communities are important for project success. These include

for example, the employment of community residents to collect and analyse information obtained in the course of surveys of the extent and nature of problems, and arrangements for ensuring genuine consultation with the people of the community on the location of the facilities to be built and other design decisions.

The targets for community action may be shaped by such factors in the local situation as: (1) poorly enforced environmental legislation, so that the urban poor often live on sites subject to flooding and high levels of pollution. (2) lack of knowledge among individuals and in the community about health problems and their causes, together with inadequate means for making a community diagnosis; (3) political constraints on the organizational capacity of low- income groups; and (4) the emergence and development within urban communities of new disease patterns, which existing health service and instruction are ill- equipped to deal with.

### **Prerequisites for community action.**

Community action is more likely to be successful when:

- \* A broad view of development is taken by both government and external agencies that recognizes that good health (and the services and institutions on which this depends) is vital to development and deserves to be given a high priority in the allocation of resources.
- \* Some parts of the physical infrastructure and related services are provided or guaranteed by government; for example, safe water-supply and excreta-disposal systems are needed if improved personal hygiene is to be feasible.
- \* Government structures, personnel and institutions favour the multisectoral, bottom-up, participatory actions essential for improving environmental health, including recognition of the right of people to organize.
- \* Policies on housing provision and improvement that facilitate self-help actions by the people themselves have replaced the largely unsuccessful



direct provision of housing by government; such policies should ensure that poorer households have access to the resources (land, credit, materials) essential for house construction, improvement or maintenance and should promote security of tenure.

- \* The Government, in partnership with the community, is committed to developing the framework within which the future city can develop; without a suitable policy framework that ensures that new houses and new settlements are developed in ways that promote good health, environmental conditions will continue to deteriorate within rapidly growing cities.
- \* The health care system is oriented towards primary health care.
- \* Elected local authorities have the power and ability to support community initiatives.
- \* The regulations on health, building, planning and land use are appropriate to local needs, resources and community preferences.
- \* Economic stability prevails and the economy is prosperous enough to support more ambitious social and health policies.
- \* A broad understanding exists, within local cultures, of the differing environmental health needs of men and women and their respective roles in community action, together with a recognition that women commonly have primary responsibility for child care, household cleaning and management, and the care of the sick-often in addition to contributing to household income- and are the adults most severely affected by poor environmental health and inadequate services. They are also very often the most active participants in community organizations or in actions aimed at improving health.

### **Attitudes and approaches to community action**

Success in expanding and multiplying community actions on environmental health problems (and other problems that affect health) depends heavily on providing community organizations with an appropriate framework and with the knowledge, advice and resources necessary to ensure that such actions are effective.

Tackling the most serious environmental health problems will call for the commitment and involvement of many new individuals, organizations and institutions. At present, most environmental health initiatives depend on government agencies that are too poorly coordinated and funded to implement continuous, multisectoral and participatory programmes. Government links

with community organizations - where these exist - are usually top-down and sectorally separated, and do not involve others who are also concerned, such as enterprises of all sizes, trade unions, politicians, professional associations, non governmental organizations, universities and community groups. A better approach would be to establish a partnership between all those involved that is designed: (1) to link multisectoral public and private formal organizations at the municipal level; (2) to encourage the development of networks of community action groups; and (3) to facilitate communications between and among such networks. Such a partnership could help to promote:

- Common goals for environmental health actions by both government and the community;
- the employment, under public or private auspices, of appropriate full-time, salaried "community action facilitators", capable of working with low income communities in problem identification and community mobilization and organization, and able to act as links between the community and municipal-level agencies;
- the selection, in the first instance by the communities, of community volunteers from the low-income groups who could carry out some of the information, mobilization and monitoring functions (for which they might be paid);
- training for professionals working in environmental health (whether from government agencies, private firms or nongovernmental organizations) to enable them to work in collaboration with low-income communities and their organizations;
- the reorientation of universities and other teaching, training and research institutions towards the direct support of community-level initiatives, their greater involvement in such initiatives, and the incorporation of community-oriented information and experience into the basic education and training of professionals intending to work in health and housing;
- a strengthened leadership role for women in low-income community organization;
- the reorientation of government employees and institutions in such a way as to facilitate and support community actions and provide the services and infrastructure which are outside the scope of community actions;
- training of new leaders at community and local government level who are capable of helping to mobilize community action on environmental health and related problems and to negotiate for resources;

- network or federations of community organizations, which can pass on experience, evaluate schemes, and develop solidarity among the participating groups;
- schools and education systems able to make use of the potential of children as agents of change in environmental health problems in the home and neighbourhood; and
- strategies that capitalize on critical public needs (e.g., child survival) as issues around which community action can be encouraged and resources mobilized.

*SOURCE: WHO - TRS 807, 1991*

## **HEALTH PROMOTION - OTTAWA CHAPTER**

Health promotion is the process of enabling people to take greater control of their health and to improve it. Its main elements are:

- \* Creating supportive environments for health,
- \* Strengthening community action,
- \* Developing personal skills,
- \* Re-orienting health services and
- \* Building healthy public policy

Through Health Education, which is an essential instrument of Health promotion, the public can gain knowledge, skills, motivation, and confidence to pursue healthier ways of life; those who advise the public about their health can enquire the communication skills they need; decision makers in organisations can be advised on introducing health policies and on the health implications of other policies; and a climate of opinion can be created which supports comprehensive strategies to promote the health of the people. Health Education is not something which only health educators do-everyone has a part to play.

*Health Education Authority Strategy 1993-98.*



## **23. WOMENS PARTICIPATION IN SANITATION PROGRAMMES (CASE STUDIES)**

Baldia project in Karachi, Pakistan relied heavily on women's initiative to improve sanitation in slum area. Almost half of the work of constructing latrine was undertaken by women and all the health committees formed had women representatives as most active members. The result was 40 percent of the households built soakpit latrines.

In Honduras, at the suggestion of a women's legal society in Tegucigalpa, barrio women expanded their group into a community wide action committee headed by women. By their initiative they got the city authorities to instal four stand pipes in their hill side slum. A community woman usually from a female headed household is hired by the community on rotation basis to be incharge of the stand pipes, to collect fees for water and to keep the water sites clean.

Source: Yangsheg Ma and Mary Elementorf (1984).  
background paper v inter Agency task Force on  
Women and water of the steering committee for  
cooperative action of the IDWSSD.pp.1-17.

### **Tuberculosis - Need for A Global Programme of control**

A primary cause of TB's resurgence in these countries has been inadequate funding for international programmes to combat tuberculosis in the developing world, where 95 percent of TB sufferers live, the report says. It underscores the need to avoid isolationist public health policies in fighting infectious diseases. "Good domestic health policy includes having a strong international health programme against diseases such as AIDS, malaria, cholera, tropical diseases and TB", Dr Kochi said.

## 24. COMMUNITY INVOLVEMENT IN DRUG ABUSE CONTROL

One may well ask what role communities could play in the control of drug abuse. Supply reduction is the job of the police. Demand reduction is the job of doctors in their treatment centres. To the extent that the police cannot stop the availability of drugs, let the health service cure those who become drug addicts, in spite of all supply control efforts.

We have ample evidence from all over the world that these traditional strategies alone do not work. Law enforcement will at times drastically reduce the availability of illicit drugs by spectacular seizures, or a vigilant narcotics police may prevent the establishment of a criminal distribution network. But such successes do not seem to be sustainable. Clinics to treat drug addicts may detoxify large numbers of them but the rates of relapse are high worldwide.

Could, then, people and communities achieve what agencies of law enforcement and health do not seem to be able to achieve? The answer is neither yes nor no. The answer is: both agencies need people, communities, to be successful. And equally, important, people NGO's and communities need Government support to be successful in their strive for a drug-free environment.

Drug abuse, thereby, becomes closely linked to health care, with health services rendering necessary support. But for successful prevention, and for caring for the disabled and chronically ill, community involvement is necessary. Only people, friends, teachers, relatives, community leaders, peers, can prevent others from becoming drug dependent. And only people, families, friends, employers, social workers, can help a drug dependent person to stay drug free.

A community-based study on pathways into drug dependence in Sri Lanka confirmed the appropriateness of a public health model in its application to drug abuse: some people grow up in highly endemic areas, pockets in city slums where anti-social activities, drug peddling and use of illicit drugs are "normal". Such people may socialize into drug use. But the majority become individually infected by others. Drug abuse spreads from person to person. Drug peddlars befriend before they offer the drug for the first time to their victims, free of charge of course for the first few times. How can we immunize youth against becoming infected from a nice, healthy 'friend'?

Awareness is certainly important. But it is not enough. An anti-drug attitude in the community and especially in youth is certainly important. But it is also not enough. It is the social climate where drugs are not 'in' and where no pro-drug subculture exists which protects youth, a social climate which only

communities can generate through their young. The full involvement of youth and their leaders will be able to increase resistance of youngsters against the befriending drug peddler. Some youngsters thus prepared will not only say 'no' to the offer of drugs but will be able to initiate action against the peddler or will help to rehabilitate a friend who has fallen victim to drugs.

A study group convened by WHO/SEARO in 1983 and 1984 reviewed the international experience regarding factors which improve outcome in drug dependent persons. The conclusion was clear: The social environment in which the detoxified ex-user lives largely determines the long-term outcome. A drug free environment, return into a family or another socially supportive environment, long-term social support, return to school or work, existence of self-help groups of ex-users and of affected families, factual knowledge about drugs and optimism in the family, are such factors. All show the need to involve communities fully. How can community involvement be achieved?

There are some examples of effective community involvement. As a preparation, people in a locality are mobilized to take care of their drug problems, drug users identified and motivated to undergo detoxification together, their parents and relatives are taught ways to handle drug problems including the skills of detoxification (for opiates). A detoxification camp is then set up and ideally all drug dependent persons in the locality detoxified together. Efforts are then made to transform them into self-help and perhaps vigilant groups to keep the locality drug free. In this fully community-based approach most of the factors known to improve outcome in dependent persons, but also those known to prevent drug abuse, are included. Such programmes now function in some parts of India, Myanmar, and Sri Lanka. They often rely heavily on ex-users and other volunteers. The degree of professional involvement varies in the different examples of this 'camp approach towards drug free zones'. But it is clear that scope for effective community involvement of the above type requires a 'community empowerment' to solve their drug problems. It requires professionals to be willing to hand over to the people as much of their skills as possible. Physicians, in their efforts towards effective community involvement should be organizers, teachers, and perhaps outreach workers. Only then will health services encourage and invite community involvement. And only then will drug abuse control programmes be able to make major contribution to the reduction of demand for illicit drugs.

*From: WHO - SEARO INFORMATION KIT - JAN, 1991*



## 25. CATALYST ROLE OF WOMEN'S ASSOCIATION- TO PROMOTE MCH & FP ACTIVITIES IN THE VILLAGES (CASE STUDY)

The members of Mathar Sangam came very close to the village level functionaries in planning and implementing various health programmes. The Auxiliary Nurse Midwife and Health Visitor having established good rapport with president, convenor and some influential members, were able to get social support of mothers in the villages for implementing MCH. Nutrition and family planning programmes. Some of the influential members after adopting tubectomy served as satisfied acceptors and opinion givers in group discussion in mather sangam. The members also extended their help and cooperation in carrying out health programmes in their areas as and when the health staff visit the village. Some members also served as Depot-holders for distributing Nirodh, and motivated mother for other methods of family planning.

The office bearers and other members of mather sangam were also given adequate training to use individual contact (interpersonal communication) in the village as an effective educational method. Through individual contacts they dispelled the doubts of the other women/mothers in respect of health programmes and particularly with regard to contraceptive methods and clarified some points where some members expressed shyness to raise questions in group discussions. Through these visits the members were able to identify receptive, nonreceptive and resistant groups. Subsequent visits were able to create a few satisfied customers. This softened the resistance and converted some of the nonresponsive mothers into responsive, some of the resistant people into responsive groups.

*Source: Athoor Experience: Action Research Monograph Series 1971,  
GIRH&FWT. Gandhigram.TAMILNADU*

## 26. CONCEPT OF MATERNAL AND CHILD HEALTH AND FAMILY PLANNING

The term “maternal and child health”, without qualification, is used in the broad and currently accepted meaning of promotive, preventive, curative and rehabilitative health care of mothers and children, and thus include the sub-areas of maternal health, family planning, child health, school health, care of handicapped children, adolescents, and health aspects of the care of children in special settings such as day care.

Maternal and child health care is not simply a form of service organized conveniently according to age and sex characteristics or a specific activity to deal with a disease. Rather, maternal and child health care is concerned with the process of growth and development, which is the foundation of human life, and it is the very nature of this process which is crucial for health and ill health, for life and death.

The achievements of full potential of each stage of growth and development largely depends on the preceding stages and is a critical determinant of the next. If physiological and psychosocial requirements are not fulfilled at each stage, the physical and mental potential of the individual to adapt and develop in a healthy way diminishes. The health of the child subsequently influences his or her health when he or she becomes an adult and health of the adult influences the care of his or her child. Thus the growth and development of one generation affects the growth and development of the next generation. Certain stages in this continuous process are more critical than others, and entail greater risks. Mother and children are considered vulnerable groups because of the special characteristics of pregnancy, infancy and young age which expose them to the risk of ill health.

Indeed the environment - natural or man-made, physical or chemical, biological or social - has significant effects on the health status of mothers and children and human development in general. The multisectoral nature of health underlines the importance of a comprehensive approach to health development in general and maternal and child health care in particular.

In visualizing the scope of, and approaches for, MCH as a programme area, careful cognizance of the factors affecting maternal and child health is essential for the effective integration of MCH programme activities with other programme areas which also address these factors. Such factors include environmental, economic and socio-cultural factors that have a direct influence on the nutritional status, water and sanitation, housing, education and literacy,

life-styles, behaviour and attitude within the family, and community and social support measures.

Family planning or the spacing of births is another important factor for the health of both the mother and the child. Hence it should be integrated with maternal and child health care. In developing countries, women not only are at a higher risk of dying from pregnancy due to their own poor health and lack of appropriate care during pregnancy and child birth, they are also at risk for more frequent pregnancies over a considerable period of their lives owing to early marriage. Many women spend their whole adult lives either in successive pregnancies or in breast-feeding and often begin this cycle before they themselves are fully grown. Too closely spaced pregnancies do not allow a woman's body time enough to recover. It has been shown that there is a relationship between higher incidence of infant deaths and short birth intervals. This relationship between infant mortality and birth interval clearly indicates the importance of family planning. With proper spacing of births, both the mother and the child benefit, which together with other MCH measures, enhance the infant survival rate, which in turn, improve the acceptance of family planning.

With the primary health care approach as the key to the attainment of the goal of Health for All by the Year 2000, the crucial importance of maternal and child health care can hardly be overemphasized. The basic principles underlying the overall strategies and policies for primary health care are fundamental to the concepts of maternal and child health care; intersectoral approach; need for total coverage; participation of individuals, families and communities; maximum use of existing resources such as traditional birth attendants, women's groups and school teachers, and so on.

As the major and essential part of action of maternal and child health care takes place within the family, the emphasis on MCH care within the health care system - specially Primary health care must be to support community and family self-reliance, especially regarding the family's capabilities in child-bearing, child-rearing, and self-care.

In short, maternal and child health care provides a mechanism for concentrating and coordinating actions for mothers and children, drawing upon and integrating the resources from many other programme areas in health and other sectors.

*SOURCE: W.H.O 1986*



## 27. THE INTERNATIONAL SAFE MOTHERHOOD INITIATIVE

“That in 1990 we should still be saying that half a million women will die worldwide in trying to perform their god-given gift of being the vehicle through which society is maintained, through which mankind is proliferated, is as unjust as it is cruel. It should be considered an affront to our humanity. It should be considered a slur on our vaunted scientific and technological achievements. It is our recognition of this unacceptable and even degrading situation that led to our starting the Safe Motherhood Initiative.” The Initiative promotes action on four fronts; first, raising women’s socio-economic, legal, and educational status; second, increasing their access to family planning services; third, improving routine care during pregnancy, delivery, and the postpartum period; and fourth, improving the quality and accessibility of treatment for obstetric emergencies. Each of these activities alone helps to improve the well being of girls and women, but the goal of safer motherhood will only be achieved if a broad strategy is used: one that strives both to raise the status of females and to increase the quality and accessibility of health and family planning services.

*The goal of the Safe Motherhood Initiative is to reduce maternal mortality by 50 percent by the year 2000.*

In South Asia, many women step on the road to maternal mortality when they are born as unwanted female infants; they continue their inevitable journey as young girls who are undernourished, overworked, uneducated, and denied access to health care; their fate becomes even more certain when they marry at a young age and become pregnant before their bodies have matured physically. Without access to family planning, they have many children during their adult lives. They work long hours, their food intake is inadequate, and they receive little or no medical attention when they are unwell or pregnant.

In most developing countries, therefore, a maternal death represents not just the result of a medical complication and the health infrastructure’s inability to cope with it. It represents a chain of interrelated factors that reaches back to a woman’s own birth. Preventing a maternal death requires not just improved health services, but also an improvement in the status and well-being of females, beginning in infancy. “The obstacles that lead to maternal death do not relate only to deficiencies in health care; they are largely social, cultural, and economic”.

Perhaps the most deeply entrenched cause of maternal death is the low value placed on female children. In Bangladesh, 93 percent of the women interviewed during the World Fertility Survey (WFS) said they wanted their

next child to be a son, and 36 percent did not want any daughters at all. Only three percent said they wanted their next child to be girl. Out of all 27 developing countries covered by the WFS, son preference was found to be strongest in Pakistan, Nepal, and Bangladesh.

Studies in various regions of India reveal that boys consistently receive more calories and more nutritious foods than their sisters, despite the largely equivalent nutritional needs of children below the age of puberty.

The same pattern can be observed in Bangladesh; one study found that the daily intake of boys under age 5 was 809 calories, while that of girls was 694. Such imbalances have serious implications for the well being of female children and the adults they become; poor nutrition during childhood makes them more vulnerable to illness, which in turn inhibits their ability to absorb the nutrients necessary for physical and mental development. Girls, therefore, are often stunted as well as underweight. This compromises their ability to bear children safely in the future.

The undervaluing of females is also reflected in how often parents seek health care for their children. In Narangwal, India, Kwashiorkor is four or five times more common among girls than boys. Boys, however, are 50 times more likely to be hospitalized for treatment of the illness. Another study in India found that families spend three times as much on health care for boys than for girls.

In some countries, the pattern of higher mortality for females continues throughout childhood, although the causes change. In Bangladesh, India, Pakistan, and the Maldives, girls aged 10-19 continue to experience higher mortality than boys. In the adolescent years, this discrepancy reflects early exposure to the dangers of childbearing.

Certain family decisions - sometimes made or supported by mothers themselves can lead to other disadvantages for female children, besides, those they face in food allocation and access to health care. One of the most fundamental is access to education. Illiteracy rates for adult women in South Asia are among the highest in the world;

Lack of access to education compromises a girl's entire future. Chandni Joshi of Nepal says, "Illiteracy is perhaps one of the greatest impediments to the improvement of the status of women in the exercise of constitutional and legal rights, in employment, in attaining equality of status and in opportunities." She describes the many social, economic, and attitudinal factors that directly or indirectly limit female access to education in Nepal:

- \* The contribution of girls to productive work which leads families to keep them at home;



- \* Parents' perception that education for girls has little or no value;
- \* Early marriage, which cuts short a girl's time in school and diminishes the value of schooling to her parental family;
- \* Teaching and learning activities that have little relevance to the daily lives of students, particularly female students;
- \* School hours that conflict with the timing that girls are occupied with household and other chores; and
- \* The high incidence of seasonal migration, particularly in mountain districts, which makes it difficult for children to attend one school consistently.

Girls' unequal access to education in South Asia is closely linked to their work burden.

"The reason for the relatively low attendance of female children in school is neither the cost of education nor the conservatism of parents, but rather the dependence of the family on the girl's labour at home and in the field..." says Joshi. "By the time they reach 10-14 years, their burden is 7.31 hours a day - nearly equal to that of adult males." The same pattern holds in Bangladesh, where girls and women in rural areas contribute significantly to the family's food and income. "Boys work outside of the home in fields for 3-4 hours; this is valued. Girls work from dawn to dusk helping mother, but this is not valued" explained Mufaweza khan of Bangladesh.

Both heavy work burdens and girls' lack of access to education are tied to the practice of early marriage. Females in South Asia have the earliest average age at marriage of any region in the world. Over one-half of girls aged 15-19 are married, compared to eight percent in the developed world. Bangladesh has the highest incidence of child marriage; one study found that 73 percent of women were married and living with their husbands by age 15.

Early marriage is also frequent in India, Nepal and Pakistan (see Table). And in all these countries, early marriage is almost universally accompanied by early childbearing. A study in Bangladesh found that more than one-fifth of adolescents had given birth by age 15, and two-thirds had given birth by age 18. Adolescent fertility rates in Bangladesh are higher than in any other country included in the World Fertility Survey.



**TABLE: Female Age at Marriage**

country	Median age at first marriage	Legal age at marriage
Bangladesh	13.3	18
India	18.7	18
Nepal	15.7	16
Pakistan	16.3	16
Sri Lanka	21.7	12-16

Since the husband's family will want young bride to prove her fertility as soon as possible, family planning is almost never used before a first child is born. As long as bearing children is seen as the main-even the only-contribution of women to society, there is little prospect of changing the average age at marriage and first birth. For this reason, Dr.Nafis Sadik argued that Safe Motherhood "can only exist in a context which not only protects mothers and their children, but offers respect and status to women independently of their function as mothers."

Poor maternal health is a reflection of cultural, economic, and social factors that deprive females of access to resources and services from infancy on. During pregnancy and delivery, women's inadequate access to health care from trained personnel, and other shortcomings of the health care delivery system, are often directly responsible for high rates of pregnancy-related complications. Action is desperately needed to address these inadequacies and reduce the risks that attend pregnancy and childbearing for the women of South Asia.

## **Pregnancy**

Because fertility is high in South Asia, women between the ages of 15 and 40 may spend more than 30 percent of their lives pregnant. In Bangladesh, for example, women tend to marry and begin childbearing young and continue to bear children until age 35 or more; there are, on average, 23 years between their first and last births. The average length of time between births is less than three years.

Even if South Asia women had access to quality health care and were well nourished, well-rested, and living in clean, healthy environments, the strain of so many pregnancies would threaten their health and well-being. In fact, the conditions in which most South Asia women live and bear children are far from optimal. In southern India, 68 percent of pregnant women are reported to be anaemic. In Bangladesh and Pakistan, the corresponding figures are 58 percent

and 65 percent, respectively. Even in Sri Lanka, where the situation of women is generally better than in other South Asia countries, nearly two-thirds of pregnant women are anaemic. High rates of anaemia in pregnancy reflect both chronic under nourishment and food taboos that render the diets of pregnant women deficient in iron and other essential nutrients. Eggs, vegetables, fruit, fish, meat, and even milk may be forbidden.

The consequences of poor nutrition-weakness and susceptibility to illness-are frequently compounded by women's heavy work burdens, which generally are not reduced during pregnancy. In a number of South Asia cultures, pregnant women are expected or forced by circumstances of poverty to work until the time of delivery. Excessive workloads contribute to the poor health of pregnant women, and may even affect the outcome of pregnancy.

Antenatal care provides trained health workers with the opportunity to detect the signs of potential complications during pregnancy and childbirth. These include high blood pressure, swelling of the hands and feet, vaginal bleeding, and severe anaemia. By providing the opportunity to either prevent or treat the complication, or to refer the woman to a higher level health facility for proper care, antenatal care can contribute significantly to reducing maternal mortality and morbidity.

Yet few pregnant women receive adequate antenatal care from trained health workers. "Doctors are to treat sick people and pregnancy is not considered a sickness," explained Dr. Syeda Feroza Begum of the Bangladesh Association for Maternal and Neonatal Health. In Bangladesh and Nepal, only 9 to 16 percent of pregnant women receive antenatal care. In India the figure is estimated at 40 to 50 percent, while in Sri Lanka and the Maldives almost all women receive antenatal care.

Dr. Kamal Bukshee of the All India Institute of Medicine state, "When a woman is at high risk of complications, warning signals are too often neglected because of women's shyness, because of lack of support from family members, or because of lack of awareness of the signals." This lack of knowledge on the part of health workers, women themselves, and members of their family and community about the dangers of pregnancy and the indicators of potential complications perpetuated harmful traditional practices and greatly increases the risk of maternal mortality and morbidity (See Case Study on matters in Law's attitude).

## **Delivery**

Untrained traditional birth attendants or female relatives may lack knowledge about basic hygiene during delivery, and customary practices

intended to speed delivery or comply with tradition may do active harm to the women in labour. Dr. Syeda Feroza Begum explained that in Bangladesh, women lie on hard mud floors during delivery, because it is believed that if a woman lies on a soft bed, the baby inside the womb will feel too comfortable and will be reluctant to emerge. Pressure may be applied to the pregnant woman's abdomen with sticks or hands, causing the uterus to rupture; dung or herbs are often applied to the vulva or inserted into the vagina, and can cause severe infection.

The inadequacy and inaccessibility of health facilities also contribute to the lack of care women receive from trained personnel during pregnancy. Facilities may lack equipment or supplies; they may be open only during hours when women are fully occupied with household or formal work responsibilities, and may not be accessible during emergencies; health personnel may treat women unsympathetically or unkindly; and facilities may be staffed largely by male workers. Who are culturally unacceptable to women in some South Asia societies. All these factors discourage women from using facilities even when they are available. And often they are not. Transport is a serious problem for many women, compounded by cultural values that restrict their mobility and prohibit them from leaving home without their husbands' permission, even for treatment of an obstetric emergency.

## **Maintaining the Well-Being of Women**

Once a woman has married and begun childbearing, her health is influenced by her social and economic environment as well as her birth history. The timing and number of pregnancies during a woman's reproductive lifetime are important determinants of her well-being. Others include her continued work burden as an adult married woman, the demands of breastfeeding and childcare, her poor legal and educational status, and, of course, her poverty. These factors also contribute to high rates of morbidity among women of reproductive age. Dr. Senanayake states.

“The most fundamental change needed is recognition that a woman has multiple reproductive health needs throughout her life cycle and a basic right to control what happens to her own body. Family planning and health programmes generally have taken a narrow view of women, as mother or women at risk of pregnancy. Most have not provided safe abortion services (in countries where abortion is legal), nor have they dealt with other key aspects of women's sexual and reproductive lives; sexual taboos and abuse; reproductive tract infection; cancer, malnutrition, chronic anaemia and stunted growth, which have their roots in the neglect of female children.”



## The Role of Fertility in Maternal Mortality

Childbearing begins earlier in South Asia than anywhere else in the world, and often continues until women are biologically incapable of becoming pregnant again. In between, women in South Asia have more pregnancies than in any region other than sub-Saharan Africa. In Bangladesh and Pakistan, for example, 62 percent of women aged 40-44 had given birth to seven or more children.

High fertility contributes to high maternal mortality and morbidity in three ways: first, it increases the total number of times a woman faces the health risks of pregnancy and delivery; second, it increases her chances of suffering a complicated pregnancy, since it is often associated with having a large number of previous births spacing births too close together, and giving birth too late in the reproductive life span; and third, in the South Asian context, high fertility is associated with an early start to childbearing-often as young as 13 or 14 - and its associated risks.

Fertility is high in South Asia because people want large families and couples rarely use a family planning method to try to regulate the timing or number of births. Dr. Samia Altaf of Development Research and Management Services in Pakistan noted that contraceptive prevalence rates are less than 10 percent in Pakistan, and have been at that level for approximately 10 years. Some other South Asian countries have seen recent increases in contraceptive use, but only in Sri Lanka is the contraceptive prevalence rate above 40 percent.

Contraceptive prevalence is generally low for reasons that relate to both demand and supply. On the demand side, both cultural and economic factors serve to encourage large families and discourage the practice of contraception. Foremost among these factors is son preference. High infant mortality also encourages high fertility.

Family planning programmes have suffered from a number of inadequacies on the supply side: they may not reach out to rural areas; they may not provide a wide choice of contraceptive methods; they may not provide enough information to counteract negative rumours or beliefs about contraception and its side effects; and supply systems may not be adequately developed.

Despite cultural and other pressures for large families, surveys in South Asia indicate substantial unmet need for family planning. "Unmet need" generally refers to the percentage of currently married women who say they want no more children, but are not using a method of contraception. Estimates of unmet need in South Asia range from around 15 percent to over 40 percent. If women who wanted no more children were able to avoid pregnancy, it is estimated that maternal mortality would decline by 40% to 62 percent.

One tragic indicator of the unmet need for contraception is the prevalence of unsafe abortion in the region. While accurate, comprehensive statistics are extremely difficult to obtain, WHO estimates that there were over 100,000 abortion-related deaths in South Asia in 1980. These abortions, often performed by untrained practitioners using unsafe methods, are a stark reminder of the desperate lengths to which women will go in order to rid themselves of an unwanted pregnancy. Even in India, where abortion is legal, unsafe abortion is prevalent and causes 15-25 percent of all maternal deaths. In Bangladesh, menstrual regulation (MR) theoretically provides a safe, effective alternative to unsafe abortion (see Case Study) However, because women lack information about and ready access to MR services, an estimated 25 percent of maternal deaths in Bangladesh are caused by unsafe abortion.

Unsafe abortion is a direct response to unwanted pregnancy; and family planning is the best means for preventing unwanted pregnancy. For this reason, and because of the role it plays in helping women to bear children when it least threatens their health and survival, family planning is an essential component of Safe Motherhood.

## **Morbidity: The Ignored Tragedy**

Pregnancy-related illness causes misery and suffering for millions of women. In addition, it reduces their productivity in the home and in the fields, and compromises the quality of care they provide to their children.

Maternal morbidity also deserves special attention because of its high prevalence. It is estimated that for each woman who dies, 10-15 others suffer serious and often permanent illness. In addition, the causes of maternal morbidity may sometimes differ from those of maternal mortality. Sexually transmitted diseases and reproductive tract infections may cause weakness, disability, or severe discomfort, but with the exception of AIDS, rarely lead to death. Programmes that only target the causes of maternal mortality are thus likely to ignore serious morbidity, with negative consequences for women and their families. A study of women in two villages in India found that 55 percent complained of having gynaecological problems. Upon examination, however, 92 percent were diagnosed as having one or more gynaecological or sexually transmitted diseases.

The findings from this study illustrate another common problem: women may not be aware that they are ill, or may be reluctant to admit to feeling unwell. Reproductive tract infections in particular can proceed to an advanced stage without obvious symptoms. Given social values and economic conditions that make women reluctant or unable to visit health facilities, such infections go



untreated too frequently. Or they may be treated only after the infection has led to infertility, which is almost always a social and economic catastrophe for a woman in South Asia.

The nutritional deficiencies suffered by many South Asia girls and women can also cause severe problems. Deficiencies can cause cretinism, goiter, and other severe disabilities. Anaemia afflicts as many as two-thirds of pregnant women in South Asia, and is frequently a contributing factor in such complications as haemorrhage and infection. It also imposes an economic cost; a study in Sri Lanka cited by Dr. Karin Edstrom of WHO found that anaemic women picked 30 percent fewer tea leaves by weight than healthy women workers, and that treating the anaemia eliminated the gap in productivity.

Another common and devastating form of maternal morbidity is the development of fistulae. Caused by prolonged obstructed labour, the majority of fistulae occur in young women during their first delivery. Often because of past nutritional deficiencies, these women - many young - suffer from cephalo-pelvic disproportion; As a consequence of fistulae, these young women may leak urine or faeces constantly from the vagina. Fistulae can be repaired surgically, but the operation is expensive and waiting lists are often long. Untreated, a young bride with fistulae may be rejected by the husband and ostracized by her community for the remainder of her life.

### **The postpartum Period:**

The care a woman receives after she has given birth is a key determinant of her ability to care for that child and to live a healthy and productive life. As stated by Dr. Khan Edstrom of WHO, "It is about time for us to stop looking at the post partum period only as a good time for advice on family planning and breastfeeding, however important these are, and to recognise that it is the period when we have to help the woman back on the road toward health and meaningful survival."

Postpartum care ensures that a woman has recovered from the strain of delivery, and is strong enough to meet the demands of feeding and caring for her infant. Coverage rates for postpartum care, however, are even lower than for antenatal care. In part, this reflects perceptions that women do not need health care except in dire emergencies as well as general restrictions on women's mobility in a number of South Asian countries. One of the important components of postpartum care is nutrition education, since a woman's nutritional status is a crucial determinant of her well-being after delivery. Some studies show that lactating mothers are an especially vulnerable group, with 46 percent of mothers consuming less than 70 percent of recommended calorie intake.



Most mothers in South Asia work, although very few are paid regular wages. Rest after delivery is essential to a woman's full recovery, but in many South Asian countries women begin working again almost as soon as the baby is born. Mothers who work outside of the home face special challenges in caring for themselves and their children, and are in particular need of support and assistance. As stated by Dr. Edstrom, "In order to help her fulfill her potential role in development there needs to be a stronger emphasis on continued support and appropriate services throughout the reproductive cycle, i.e. before, during, after and in between pregnancies."

Maintaining the well-being of women, therefore, requires a comprehensive approach that acknowledges the central importance of childbearing to the lives of adult women, but which also looks beyond their reproductive role to all facets of their lives. Women are not only mothers; they are wives who require attention to their reproductive and general health; they are workers who need job security, decent wages, and a healthy work environment; they are citizens who require respect for their legal rights; and they are community members who deserve acknowledgement for their contributions to society.

## Preventing Maternal Mortality

### The Basic Principles

- \* *Mobilising political will and commitment:* The support of decision-makers at all levels-parliamentarians and government representatives at the central level, local officials at the community level, and husbands at the family level-is essential to the development and implementation of effective programmes. These are the people who allocate resources, change laws and policies, and carry out activities that mean life or death for women. For this reason, women themselves need to be better represented in decision-making circles. Politicians listen most often to their electorate; and for this reason the impetus for Safe Motherhood must come from the people themselves. They need to understand and believe in its importance to their well-being, and they need to demand that action be taken in support of its goals.
- \* *Involving community members:* Achieving Safe Motherhood requires a long-term, serious effort. In order for programmes to be sustained, they must be designed to meet the needs, priorities, and preferences of the people they are intended to benefit. The most effective way to ensure the appropriateness of programmes is for community members to be the driving force behind their development, from the start of the process. Women and young people in particular must be involved.

- \* *Integrating the activities of non government organisations into Safe Motherhood programmes:* NGOs are widely recognised as playing a key role in their societies. They are the innovators; their roots are in the community, and they reach groups that are often neglected. Because of their lack of resources, cost-effectiveness in designing and carrying out programmes is, for them, a matter of institutional survival. Therefore, they provide examples of how to translate ideas into action quickly, effectively, and at a low cost.
- \* *Sharing information, ideas, materials, and experiences within and among countries:* Such exchanges provide an opportunity to gather information on approaches that have been tested in other environments, and to discuss the advantages and disadvantages of these approaches directly with those who have been involved in testing them. Such cooperation and collaboration-which should take place before programmes are developed and implemented-can increase effectiveness and save both time and money.
- \* *Involving the media:* The media-newspapers, radio, television, and other, public information channels-can advance the goals of Safe Motherhood by reaching a broad audience in critical ways: first by helping to create awareness about Safe Motherhood ; second, by generating public consensus on the need for action; and third, by conveying or reinforcing messages about the importance of specific problems and the need for specific action.
- \* *Sensitizing boys and men:* Safe Motherhood cannot be achieved without the support of men. Educating them, taking their ideas into account, and mobilising their support must be key strategies in any Safe Motherhood programme. The education process must begin in childhood, shaping the attitudes and priorities of boys in order to affect their behaviour as brothers, husbands, and leaders.

Long term action must begin to address the fundamental constraints women face in becoming full partners in their societies. These actions-both the short-term and the long-term-must proceed hand-in-hand, since they reinforce and support each other. Improving women's social, legal, and economic status, for example, will help ensure that they use available health and family planning services. Improving their health and reducing their fertility will enable them to participate more effectively and productively in the social and economic development of their communities.



## **Actions to improve the Well-Bearing of Girls and Women**

- \* *Education:* Improving female education is perhaps the most fundamental and far-reaching strategy for promoting positive social development. It is linked directly to improved health for children, women, and other family members, greater use of family planning, increased earning capacity, improved decision-making, and higher status. The obstacles to increased education for girls and women are both economic and socio-cultural. To address these obstacles, expanding and improving the educational infrastructure, both formal and informal, training more women teachers, adapting curricula to make them more relevant to women's lives (e.g., offering family life education in schools), and making school hours more flexible to take into account the household and other responsibilities of girls and women are needed. The most significant obstacle to female education may be the perception that it is unnecessary for girls to go to school. Changing this perception will require a transformation in general attitudes toward women's worth and roles. Information campaigns can stress the advantages to a girl's parental and marital roles of educated daughters and wives. Subsidies to help cover the costs of schooling for girls might also help increase female enrollment rates. Perhaps more importantly, political and social leaders must visibly and actively support female education for the benefit of the family and the nation.
- \* *Social values and attitudes regarding women:* The undervaluing of women underlies many of the problems of higher female than male infant and child mortality; low contraceptive prevalence rates; early age at marriage and an early start to childbearing; low coverage rates for antenatal and other health services; chronic malnutrition and anaemia; women's low wages; and their lack of access to credit and income-generating opportunities. Changing these practices and the attitudes underlying them is a monumental task, and one that must be undertaken gradually. It will only be achieved through the combined effects of policies and programmes at the community and national levels on many fronts, public education about women's contributions and potential must be a key element of efforts to improve women's status.
- \* *Women's legal rights and status:* In many countries, legislation already exists that mandates fair and equitable treatment of women in terms of property rights, marriage and divorce, guardianship of children, employment, and inheritance. Where such legislation does not exist, it should be written and adopted. Where it exists but is rarely observed in practice, as



is frequently the case with age at marriage laws, action is needed on two major fronts; first, education for women and men about women's rights; and second, efforts to challenge discriminatory treatment of women within the framework of the legal system, in order to publicise the legislation and encourage women to insist on their rights. Finally, interpretations of religious law vary by country; information campaigns can encourage those interpretations that are most favourable to women.

- \* *Women's work burden:* The heavy work burden imposed on girls and women, even during pregnancy, is a significant cause of their poor health and limits their ability to learn and improve their lives. Easing women's household responsibilities can be achieved in several ways: by encouraging other family members to help with household chores and field work, particularly during the period of pregnancy; and by developing technologies for the tasks women perform that will save them time and energy.

- \* *Income generation for women:*

Women's access to income in much of South Asia is limited; programmes for training and credit in agriculture, micro enterprise development, and marketing rarely target women, and therefore almost never include them. A conscious, focused effort by governments and aid agencies can change this inequality.

Women's work opportunities need to be culturally appropriate, flexible, and more remunerative; support services, such as child care, are essential to increasing women's ability to work. Raising women's income is likely to improve not only their health and welfare, but that of the entire family. Studies indicate that when women earn money they are more likely than men to spend it for the benefit of the entire household.

## **Action to improve Health and Family Planning Service:**

In many cases, implementing a Safe Motherhood strategy requires improving existing services, in others, new programmes will need to be designed and put in place. Each country needs to assess its own needs, resources, and capabilities in order to ensure the best quality, most comprehensive services possible.

Effectiveness and sustainability are key characteristics of a sound health strategy. They can only be achieved if beliefs and practices concerning health behaviour and the utilisation of health services in the community are fully known and understood. To ensure that health care delivery systems meet people's needs as they perceive them, the community must be involved in

identifying priority health needs, designing programmes and technologies, and providing services.

During all phases of developing a health programme, the need to treat women and community members with compassion and dignity must be emphasised. This principle must be stressed especially during training of health workers. It is also critical that health services be designed to provide the most essential services to the most vulnerable, needy groups; in terms of maternal health, this means family planning services, antenatal care, and trained attendance during delivery for all pregnant women, particularly those at high-risk of complications and those residing in isolated areas rarely reached by health services.

One of the most important-and most neglected-Safe Motherhood strategies is to ensure adequate health care for women throughout their lives, not only during pregnancy and delivery. This should include nutrition education (and, if necessary, supplementation) for girls and women, health education about the prevention and detection of illness, and diagnosis and treatment of infectious and parasitic diseases. Special efforts may need to be made to ensure that basic services are used by girls and women, who tend to use available health services much less frequently than boys and men.

## **Reproductive Health Services:**

*The Basic Components.* Reproductive health services for women should be available at all health facilities, at times convenient to women, offered by providers who are culturally acceptable to them, and at a cost they can afford. Essential components of these services are as follows:

1. *Family planning services* should offer a broad range of safe, effective contraceptive methods and full information on those methods. Women and men must be able to choose the method they consider most appropriate for them. Depending on the method and the level of medical care it requires, contraceptive services should be available at all levels of the health care system and, when appropriate, via community-based distribution, social marketing, and the private sector.

2. *Antenatal care* should provide preventive, promotive and basic curative services. Health care workers should be capable of identifying problem pregnancies, providing basic treatment for some complications, referring women to higher level health facilities when necessary, and offering health education concerning pregnancy, childbirth, the postpartum period, and family planning.



3. *Care during labour and delivery* should be provided by trained health workers who are knowledgeable about hygienic procedures, able to provide adequate care for uncomplicated deliveries, and able to recognise and refer complicated deliveries to appropriate facilities in a timely manner.

4. *Emergency services* should guarantee that women who suffer from obstetric emergencies receive the care they need. Services should include arrangements for transport to referral facilities, which must be adequately equipped, supplied, and staffed to deal with such complications as obstructed labour, eclampsia, haemorrhage, and the consequences of unsafe abortion.

5. *Postnatal care and counselling* should include an assessment of the health status of the mother and child, treatment for any remaining discomfort or complications, and information on the proper care of both mother and child to guarantee their continued good health.

6. *Breastfeeding* should be supported and promoted. Counselling and public information should be offered, emphasising the benefits to the infant in terms of nourishment and disease prevention, and the benefits to the mother in terms of spacing pregnancies and preventing breast cancer later in life.

7. *Safe abortion or menstrual regulation services* should be offered where they are legal. Information should be available about where and when such services are available, and women should be educated about the signs of pregnancy and the period during which abortion and MR can be legally and safely provided. Health facilities should have the capacity and personnel to treat the complications of unsafe abortion humanely, especially where abortion is illegal.

8. *Detection and treatment of sexually transmitted diseases*, including AIDS and reproductive tract infections, should be a routine component of health care for women, particularly given the hidden nature of many of these illnesses and disabilities.

Effective programme strategies and technologies include home-based maternal records and obstetric flying squads. While not all such strategies may be feasible in all communities, for cultural or economic reasons, creativity and dedication can help ensure that women are provided with the care they need. Basic principles that should guide the provisions of health services include ensuring that all facilities have appropriate equipment, supplies, and personnel; linking together all levels of the health system-community, primary, and first referral - via supervision and communication network; and ensuring that services are monitored and evaluated according to established standards.

One of the key components of a Safe Motherhood health strategy is the training of appropriate personnel and their deployment throughout the



country according to need. The vast majority of obstetrician/gynaecologists, physicians, and even nurse-midwives work in hospitals and urban areas. Increasing the number of personnel trained in practical midwifery and ensuring their distribution to rural areas, through incentive programmes or other means, are important steps. So is increasing the number of female obstetrician/gynaecologists, particularly in communities where male health workers are not acceptable to women.

Another strategy is to ensure that physicians and other medical personnel are trained using a community-based primary health care approach. This is the policy at the Aga Khan University which “has committed 20 percent of the curriculum in each of the five years of medical school and three years of nursing school to Community Health Sciences...Thus the students complete their medical course with extensive experience in some of the most deprived urban and rural communities of Asia.”

## **The Role of Traditional Birth Attendants.**

Traditional Birth Attendants (TBAs) are an important element of a Safe Motherhood strategy, because of their accepted role in the community and the value of much of their traditional knowledge. There should be a shift from traditional birth attendants to trained birth attendants; and the training they receive must be based on a full understanding of their limitations, as well as their strengths. The essential components of a TBA strategy were identified as follows:

1. Defining the most appropriate role for TBAs given their historical role and functions in the community, in keeping with the capacity and structure of the formal health system. TBAs and other health workers need to know what TBAs can and should do.

2. Training and retraining on basic skills, including the identification of problem pregnancies, safe management of normal deliveries, referral of problem cases, and elimination of unsafe traditional practices. The training of TBAs or other community members who attend deliveries on a regular basis should be appropriate to their level of motivation and education.

3. Strengthening the linkages between TBAs and the formal health system. TBAs should be properly and frequently supervised to monitor their practices and effectiveness. In order for this monitoring to be effective and to ensure that referrals take place on a timely basis in all appropriate cases, TBAs must feel that they are valued by the health system. Therefore, their traditional learning should be respected, and practices that are not actively harmful should be encouraged and supported.

## **The Role of Information, Education, and Communication.**

In order to achieve maximum effectiveness and make the best use of scarce resources, health services must be accepted and fully utilised by the people. In addition, community members must themselves understand the basic principles of good health and disease prevention. IEC strategies have a crucial role to play in ensuring that these complements to the health care delivery system that are in place. IEC campaigns help create demand for services, and ensure that people know where, when, and why to use them.

IEC can also reduce the need for people to use health services, by educating them about how to prevent poor health. Proper nutrition, the symptoms of pregnancy and related complications, and family planning are all topics which the community should be educated. IEC campaigns must be carefully designed; different approaches must be used for different audiences or messages. For example, a campaign that aims to combat lack of knowledge about such a topic as proper nutrition during pregnancy should use a different approach from one that aims to influence deeply-held traditional beliefs or practices such as food taboos during pregnancy. Some recommended IEC guidelines include:

1. Working through appropriate groups or individuals in the community (religious leaders, traditional healers, mothers-in-law, older people, respected public figures, users who are satisfied with the quality of a service, etc.) to convey messages and impart essential information.

2. Using the existing network of information systems, including the media, popular culture, public debates, and so forth, to reinforce and complement messages. Other community-based programmes, including sanitation, child survival, and agricultural extension, can also be used to convey information about Safe Motherhood.

3. Ensuring that the factual content of messages is accurate, but that its presentation is adapted to the language and culture of the people being addressed. Concepts that may be new to the community must be presented in a context that people can understand, using familiar terms.

4. Tailoring messages within each community to address the groups that need to be reached most directly, e.g. men, young people, non-literates, community health workers, policy-makers, religious leaders, and others. The priorities, knowledge, and attitudes of each of these groups need to be understood and taken into account in the design of an IEC campaign.



## **Coping with Obsteric Emergencies: The Role of Transport and Communication.**

Ideally, early detection of potential problems during pregnancy and delivery should prevent the need for emergency care. But serious complications can develop unexpectedly. One strategy that can address the problems created by both expected and unexpected complications is the development of maternity waiting homes, particularly in areas where trnasporation is unavailable or unreliable. These homes are established near a health facility or hospital capable of handling obstertic emergencies and are generally staffed by midwives or trained TBAs. A woman can stay at the waiting home from a week or so before she is due if a complication develops, she can be moved quickly and easily to the health facility for treatment, and if her delivery is uncomplicated she can be delivered in the waiting home.

Where maternity waiting homes are not acceptable or feasible, mechanisms must be developed to link women with health facilities in time when they suffer from an obstetric emergency. The two key mechanisms are communication and transport. Ideally, all means of communication in the community-short-wave radio, telephone, etc.-should be available for use in the case of an obstetric (or other medical) emergency, in order to contact the nearest health facility and arrange for transport. All available transport facilities should be utilised, and there should be a standing agreement with the owners of the vehicles to make them available in emergencies.

## **Resource Mobilisation and Utilisation**

By definition, maternal and child health is an integral component of primary health care. The reality in most developing countries, however, is that only a small percentage of the health budget is allocated for MCH. In South Asia the health sector accounts for 3-5 percent of most government budget; 20 percent of this total is for MCH. Within this already small component, only a fraction of expenditure focuses on maternal care. The vast majority of the expenditure classified as MCH is actually on such child survival intervention as immunisation, oral rehydration therapy, and grwoth monitoring.

In order to change this situation, decision-makers need to be aware of both the social and economic costs of maternal morbidity and mortality-the costs, in others words, of not investing in Safe Motherhood. This applies not only to governments, but also to non-governmental organisations, donor agencies, and others that can play a role in achieving the goal of safer motherhood.



Decision-makers also need accurate, locally-specific information on the costs of implementing maternal health programmes. Ensuring that resources are maximised requires broadening their definition; resources are not only financial, but also institutional, human, technical, and informational. It is also essential that the principles of cost-effectiveness be followed in making investment decisions for Safe Motherhood, so that resources are allocated to the most critical problems and the most effective interventions. Finally, once resources are allocated, efficiency in resource management is essential to the credibility and effectiveness of Safe Motherhood programs.

## **The cost of Maternal Mortality and Morbidity**

The lack of investment in maternal health care reflects a lack of recognition of the direct and indirect costs of high maternal mortality. The direct costs to health facilities of treating the complications of pregnancy and childbirth are generally higher than the cost of preventing such complications in the first place. In Bangladesh, for example, a study cited by Dr. Carol Hogue of the U.S. Centers for Disease Control found that providing menstrual regulation services led to a 72 percent reduction in admission for septic abortion, and a cost savings of 5,000 bed days per year. Given the high cost of treating such complications as obstructed labour and the consequences of unsafe abortion, there is little question that preventing these problems through the provisions of antenatal care, family planning and safe abortion or menstrual regulation services is a far more effective way to use existing resources-as well as a far more humane way to treat women. The benefits of investing in Safe Motherhood, outweigh the costs, even without considering indirect benefits."

The indirect benefits of Safe Motherhood are also considerable. Given the significant role women play in economic production and social development, the death of a woman during her most productive years imposes a substantial loss on the family and society. The importance of women's well-being to the survival of infants is well documented.

In addition, the lives of older children are significantly affected by a maternal death: girls, for example, are almost certain to be removed from school and required to take over the childcare, household, field, and other chores of a mother who has died. Assigning a monetary value to such longterm social costs is difficult, if not impossible. But identifying the costs, listing them, and taking them into account when allocating resources among conflicting priorities is essential for equitable, sensible decision-making.

## Information:

### *The Neglected Resource*

For many years, maternal mortality was ignored as a social and economic problem because few people were aware of its dimensions and consequences. Research can provide crucial support to the achievement of Safe Motherhood and should focus on the following:

1. Providing information on the causes and extent of maternal mortality and morbidity in specific regions of a country in order to help identify priority problems and areas;
2. Investigating and reporting on the cost, effectiveness, and safety for addressing the problems identified.
3. Evaluating operational procedures as well as the overall impact of a programme in achieving its goal.

Many governments and donor agencies are reluctant to invest in research preferring to support programmes that they view as having a more direct impact on improving people's welfare. Research, however, is essential to ensuring the long-term effectiveness of such efforts. In order to do so, research findings must reach programme managers promptly, and must be presented in a format that is understandable and directly relevant to the decisions they must make. Information and the reasons for their effectiveness should be shared widely, both nationally and internationally, so that successes can be replicated when the social and economic context allows.

In addition to operational research to assess the effectiveness of specific interventions, programmes should be monitored continuously as a matter of course.

Continuous monitoring enables programme managers to identify and carry out modifications in programme strategy when this is necessary. The information needed to alter strategies when necessary, and the flexibility to do so, are essential for maximum effectiveness and efficiency.

Dr. Carol Hogue of the U.S. Centers for Disease Control emphasises that the lack of reliable, comprehensive information about the causes and dimension of maternal mortality can be a drawback when strategies are being developed to address the problem. Effective vital registration systems are almost non-existent in most of the developing world. Some maternal mortality data are obtained through household surveys, but most are gathered via hospital-based studies, which often underestimate maternal mortality. For example, many deaths occur outside of a hospital setting, and a significant proportion of maternal deaths in the hospital may take place outside of maternity or obstetric

wards. Dr. Hogue recommends the use of multiple sources, including newspapers, community health workers, and reports from individual physicians, to supplement and verify the information gathered through vital statistics or specific maternal mortality studies. A number of other research methodologies to improve the accuracy of data on maternal mortality have been developed in the U.S. and elsewhere which, if appropriately adapted, could be used in the South Asian context.

The needs are tremendous; the ideas and technologies exist; the resources are being mobilised; and now the commitment must become action. Only in this way will hundreds of thousands of young girls, adolescents, and adult women in the villages and urban slums of South Asia be saved from the fate that otherwise awaits them during pregnancy and childbirth.

“Let us work together to help motherhood be what it should be- the gift of life, not the threat of death. Safe Motherhood is an investment in the mother of today. It is an investment in the world of tomorrow.” Dr. Fred Sai, WORLD BANK.

(Abstracted from a report of the Safe Motherhood South Asia conference Lahore 1990)



## 28. SOCIAL WELFARE INVESTMENTS AND HEALTH INDICATORS IN SRI LANKA AND KERALA STATE, INDIA (CASE STUDIES)

In the context of the low-income countries of South Asia, Sri Lanka and the Indian State of Kerala stand out for their remarkable success in improving the social welfare of their people despite limited resources. A number of factors relating to social and political development and government policy help explain their achievements. These include:

1. A historical commitment to health as a social goal, which translated into significant government investments in health services in general and primary health care in particular.
2. A strong social welfare orientation in development policies, which contributed to investments in health, as well as in education, transport, and equitable economic development.
3. The equality of health service coverage, with an explicit emphasis on providing women, children, and the poor with adequate access.
4. Widespread participation in the political process, which provided people with a channel through which they could demand social welfare services.

In addition, both Sri Lanka and Kerala State have highly educated populations, which has a significant impact on health in two respects: first, an educated population is more likely to demand effective and efficient health services from the government; and second, a well-educated female population is more likely to practice positive preventive health measures, take advantage of available health services, and use family planning.

*Sri Lanka:* Although Sri Lanka's per capita income places it squarely in the "low-income country" category, its health and social indicators are far above those for all other countries categorised as low-income by the World Bank. In terms of infant mortality (33 death per 1000 live births), life expectancy (73 for females, 68 for males), the crude death rate (6 deaths per 1000 population), and literacy (87 percent), Sri Lanka's level of social welfare is, in fact, better than of most middle-income countries.

This achievement reflects the policies implemented by the government since the 1930s, and specifically its strong commitment to meeting the basic needs of the Sri Lankan population for food, education, and health services. Economic policies have emphasised increasing the agricultural productivity and income of the rural poor. Social welfare services, especially during the

immediate post independence decades, have focused on increasing the numbers of medical facilities and trained personnel, strengthening maternal and child health services, and controlling infectious diseases. The expansion of educational facilities provided the population with access to free education.

The government's emphasis on equitable social and economic development has applied to different income groups, geographic areas, and to both sexes; There is no differential between male and female access to primary education.

*Kerala State, India:* The per capita income of Kerala State is below the national average for India, and its population density is the highest of any state in the country. An estimated 47 percent of the population lives below the poverty line. Despite poor economic conditions, Kerala State has the highest literacy rates and among the lowest mortality rates in India (in 1981, literacy was 70.4 percent in Kerala, 36 percent in India; infant mortality was 40 deaths per 1000 live births, compared to a national average of 121). The discrepancies between males and females for such social indicators as literacy, life expectancy, and infant mortality are also much lower in Kerala than in most of India.

A number of factors help explain Kerala's relatively good health and social indicators. Because of government investments in the health service infrastructure, medical care is widely available and evenly distributed geographically. And these services are well utilised by the people. In 1980, almost 50 percent of deliveries took place in a medical institution, while another 25 percent were attended by a trained professional.

Most analysts point to a historical emphasis on public health and education as the explanation for Kerala State's achievements. Specifically, the state government has invested a significant portion of its resources in the provision of health care facilities and in comprehensive public health measures. In addition, high health service utilisation rates reflect the level of education and health consciousness of parents, especially mothers. A tradition of social and political activity, and widespread awareness of the basic right to have access to services, have led the poor in Kerala to demand and use such services.

-Based on "Good Health at Low Cost," proceedings of a 1985 conference held at the Bellagio Conference Center, Italy, sponsored by the Rockefeller Foundation.

## 29. KNOWLEDGE, ATTITUDES, AND PRACTICES OF MOTHERS-IN-LAW IN NEPAL (A CASE STUDY).

In Nepal, as in most of South Asia, the joint family system prevails, and mothers-in-law play a key decision-making role with regard to family activities and welfare. Daughters-in-law, particularly those who are recently married, carry out their domestic activities under the close supervision and guidance of mothers-in-law. Mothers-in-law play a major role during pregnancy and childbirth, and attend most deliveries in rural areas. Additional help is sought only if the mother-in-law so decides. Common practices include cutting the umbilical cord with unsterile instruments and the enforcement of food taboos during pregnancy and the postnatal period.

With the ultimate goal of changing unsafe practices and beliefs concerning pregnancy and childbirth in Nepal, a survey was conducted to assess the knowledge, attitudes, and practices of mothers-in-law, and to determine the potential for changing some of these practices through community education programmes. A total of 150 mothers-in-law from two villages were interviewed; over 97 percent were illiterate, and almost 80 percent had had more than five births. The survey indicated that 63 percent of daughters-in-law were illiterate, and over 77 percent had no antenatal checkups. More than 72 percent of daughters-in-law had home deliveries, of which 91 percent were conducted by the mother-in-law. The mothers-in-law shared the following beliefs concerning maternal care:

- \* 75 percent said an antenatal check-up was not necessary;
- \* 75 percent did not give extra food to their daughters-in-law during pregnancy;
- \* 72 percent used a razor blade to cut the cord, and none of those interviewed sterilized the tool before cutting the cord.

The survey also found some positive beliefs and practices:

- \* 69 percent of mothers-in-law said that family planning was necessary, although a majority of daughters-in-law did not use any family planning method;
- \* 71 percent of daughters-in-law rested for six weeks or more following delivery.

Based on these results, the researchers worked with local health workers to conduct educational sessions for groups of 15-25 mothers-in-law. The three-day sessions were designed to be simple, keeping in mind the largely illiterate



audience. Using visual aids and the local language, the sessions focused on proper antenatal care and nutrition during pregnancy; identification of high risk pregnancies; aseptic precautions during delivery; complications of labour; postnatal care (including family planning); and immediate care of the newborn.

There were no drop-outs, and the majority of participants demonstrated a high rate of enthusiasm for and acceptance of the information being presented. A test of knowledge and understanding was conducted at the end of the sessions, and the researchers clarified any remaining misunderstandings on an individual basis. Work is now being conducted to assess whether actual practices have changed, and the impact on the health and well-being of daughters-in-law and their infants.

-Based on paper prepared by Prof.Sanu M.Dali, of Obstetrics and Gynaecology, Institute of Medicine, Tribhuvan University, Nepal.

### 30. ROLE OF MENSTRUAL REGULATION IN SAFE MOTHERHOOD (A Case Study).

Women resort to abortion because of rape or incest, because they have been abandoned by their husbands, or simply because they cannot care for another child, financially or emotionally. Most women want to have the right to choose whether to become pregnant, and whether to continue a pregnancy. In most developed countries, women have this right; in most developing countries, they do not.

In Bangladesh, a procedure called menstrual regulation (MR) has been officially offered by government hospitals and clinics since 1975. The government defines MR as “an interim method for establishing non-pregnancy.” The procedure, which is safe, quick, and has a low complication rate, consists of the use of a plastic cannula and syringe to evacuate the uterus. It is performed up to six weeks after a missed period.

While MR is officially available in all government health facilities, the government of Bangladesh does not advertise or promote its use for fear of negative political consequences. As a result, many women resort to unsafe procedures performed by untrained providers to rid themselves of an unwanted pregnancy. These unsafe procedures include the consumption of herbs to induce abortion, the insertion of sticks or other objects into the uterus by dais (traditional birth attendants) or by the women themselves, or the performance of MR too late in pregnancy or with inadequate equipment. A 1987 study found that 75 percent of MR complications were caused by untrained providers.

Women obtain services from untrained practitioners because they lack knowledge about where to obtain safe MR services and because they do not know that the procedure can only be performed within six weeks of a missed period. As many as one-third of MR clients are rejected by trained service providers at health facilities, most often because they ask for the procedure too late in their pregnancy.

An estimated 80 percent of abortions in Bangladesh are the result of women's lack of access to MR services, the low quality or inappropriateness of those services, or the lack of information about where, when, and how those services can be obtained. Up to 25 percent of all maternal deaths in Bangladesh are due to unsafe abortion.

Legalising abortion or MR, therefore, is not enough. Services may still be effectively unavailable because of high cost, insufficient numbers of trained personnel, or lack of information about where and how to obtain the procedure. There is clear need for additional trained personnel and facilities capable of

treating septic or incomplete abortion. There is also an urgent need to educate women about their bodies, so that they know when they became pregnant, and to inform them about where MR services can be obtained safely.

Good quality, easily accessible family planning services are always the optimal strategy for reducing the prevalence of unwanted pregnancy and preventing unsafe abortion. Experience in Bangladesh shows that MR is a good entry point for introducing women to contraception. One study found that 88 percent of MR clients accept a family planning method after the procedure. Of these, 72 percent were still using contraception one year after the procedure, although 12 percent had switched methods.

In conclusion, therefore, Bangladesh illustrates how the provision of quality MR services can reduce the incidence of unsafe abortion, and the high rates of maternal mortality and morbidity that are a common consequence of unsafe abortion. Bangladesh also demonstrates, however, that MR services must be of good quality and widely available, and that they must be accompanied by information campaigns that reach those women most in need. Both government agencies and non-governmental organisations in Bangladesh train physicians and paramedics how to perform the procedure. A coordinating committee has been established to discuss problems related to service provision, and to publish and disseminate study findings.

-Based on paper prepared by Sandra Kabir, Bangladesh Women's Health Coalition.



## 31. NEED FOR MATERNITY BENEFITS FOR EMPLOYED WOMEN (A Case Study)

In India, 94 percent of all employed women work in the formal sector. They are generally poor and malnourished, have little education, and work long hours at below minimum wage. Work is not available on a steady basis, and labourers must often travel considerable distances to find employment.

Self-employed women face many challenges in trying to balance their roles as wage-earners, housewives, and mothers. The challenge is most striking during pregnancy, the vast majority of these women do not have access to any maternity benefits, and because of their poverty they have little choice but to work until late in pregnancy and return to work soon after childbirth. The demanding physical labour performed by many of these women can threaten their health and that of their infants. They are more likely to face complications during pregnancy and childbirth, bear low birth weight infants, and suffer from poor health during the postnatal period.

The Indian government provides for maternity benefits under two official Acts that apply to the employees of factories, mines, plantations, shops, hotels, and other large companies or formal establishments. The eligibility conditions exclude all temporary, seasonal, and contract workers from receiving benefits. In Gujarat State, for example, less than three percent of all employed women qualify for maternity benefits.

In recognition of the problems faced by seasonal, temporary, and self-employed women workers, the Self-Employed Women's Association (SEWA) decided in 1975 to develop a maternity benefits scheme. SEWA has been supporting poor, self-employed women since 1972, primarily by helping them organise themselves into unions and cooperatives. SEWA has 100,000 members in Gujarat and other states. A survey of 500 members who were not making regular payments on their loans from the SEWA bank found that 20 of these women had died from causes related to pregnancy.

SEWA's maternity benefits programme has been implemented in several rural and urban areas where SEWA is active. In practice, the programme included the provision of health services in collaboration with the government health system and village midwives, cash support to help pay for delivery costs

(equivalent to six or four weeks at minimum wage, depending on whether it was the first or second pregnancy), and nutritional supplementation for women during pregnancy. In addition, SEWA organisers help provide health education and postnatal care.

While complete data to analyse the impact of the scheme are not available, the information gathered in one district indicates that maternal mortality among the women covered by the maternity benefits programme had fallen below the rate generally found among rural women in India. SEWA's review also revealed that women who participated in the scheme were substantially more likely to use available health services. In October 1988, for example, 57 percent of all pregnant women in one programme area were registered with their local primary health care center, compared to 35 percent before the programme began. In addition, the women indicated that they believed the quality of antenatal care had improved because of the maternity benefits programme. Follow-up interviews revealed that cash payments were used largely for expenses associated with pregnancy and childbirth, and to increase food intake.

The most significant problems encountered included poor coverage of the population most at risk, logistical and administrative obstacles, financing, and concern that the scheme might have a pro-natalist effect. The major difficulty encountered with the implementation of the scheme was the timing of payments; while SEWA organisers tried to ensure that pregnant women are registered as early as possible (generally in the fifth month), only 10 percent of women received the payments before delivery. Most did not receive payment until up to three months after childbirth.

In the process of advocating for maternity benefits programmes, SEWA has held discussions with a variety of public professionals, policy-makers, and government officials at the national and state levels. Its ongoing work with village women has confirmed the importance of maternity benefits to the millions of poor working women in India. A number of possible funding models have been discussed, most of which work through state government organisations that contract home-based or temporary workers. SEWA plans to continue advocating for the implementation of government-sponsored maternity benefits schemes for landless female labourers.

- Based on paper prepared by Mirai Chatterjee, Self-Employed Women's Association, India.

## 32. THE REDUCTION IN MATERNAL MORTALITY IN FAISALABAD, PAKISTAN (A Case Study)

A 1977 survey of rural and urban Faisalabad, Pakistan found a maternal mortality rate of 1000 per 100,000 live births. This extremely high rate reflected a number of interacting factors; lack of family planning services, which contributed to high birth rates, large numbers of unwanted pregnancies, and, therefore, to high rates of unsafe induced abortion; and inadequate knowledge about maternal health care among Traditional Birth Attendants (TBAs) and the community, which led to high rates of pregnancy-related complications. In order to address these problems, a programme was initiated with the following components:

1. Refresher courses for TBA and Lady Health Visitors (LHVs): TBAs, first in urban and later in rural areas of Faisalabad, were taught about aseptic delivery, recognition and referral of abnormal cases, registration of normal births, and family planning. These courses were conducted in hospital, health units, and maternal and child health centres, with LHVs accompanying the TBAs. TBAs participating in the refresher courses were given delivery kits. The courses were repeated every year over a ten-year period; by 1988, 8022 TBAs had participated in the programme.

2. A mobile obstetric unit: This unit conducted antenatal check-ups, offered family planning services, and provided iron supplement tablets.

A second survey in 1987 found that the maternal mortality rate had dropped to 186 per 100,000 live births. In 1989, additional components were added to the programme: a flying squad began offering free services for obstetric emergencies, and an intensive community education campaign to make 1989 "The Year of the Mother and Child" was carried out in the city. The campaign worked through "street camps," radio, newspapers, public lectures, handbills, signboards, and other information channels to reach the general public and raise awareness about the dangers of pregnancy and childbirth and the importance of timely professional care. The campaign also focused on informing people about the services available, and led to a dramatic increase in the utilisation of the flying squad.

The campaign succeeded in registering almost all untrained TBAs, who were then given intensive training at local MCH centres. In 1989, 298 TBAs were trained in the city. In addition, meetings were held with local TBAs and LHVs to introduce them to flying squad services, and to educate them about the



cause of maternal mortality and morbidity, the importance of antenatal care, breastfeeding, and family planning. These meetings were repeated during the year-long campaign; the audience was expanded to include pregnant women and at the request of these women-mothers-in-law, other community women, and men.

Additional campaign components included the provision of free maternal care services in the hospital, the opening of additional MCH centres in city slums and rural areas, and a survey of maternal deaths during home delivery, which identified whether a TBA had been responsible and, if so, provided additional training to that TBA.

By 1989, the maternal mortality rate in Faisalabad city had fallen to 86 maternal deaths per 100,000 live births. Many of the activities described above are continuing during 1990. Plans are being made to duplicate the Faisalabad city campaign in rural areas of the division, where 1990 has been declared "The Year of the Motherhood and Child."

- Based on paper prepared by Dr. Altaf Bashir, prof, and Head of Dept., Gynaecology and Obstetrics, Punjab Medical College, Pakistan.

### 33. THE ROLE OF TRADITIONAL BIRTH ATTENDANTS IN SAFE MOTHERHOOD (A Case Study)

Traditional birth attendants (TBAs) deliver an estimated 75 percent of all infants in Pakistan. In the absence of substantial investment to improve the formal health system, upgrading TBA skills would appear to be an obvious way to improve maternal and infant health. In practice, however, it is not always an effective or optimal strategy.

The lack of effectiveness of TBAs, and the perpetuation of dangerous and unhygienic practices during delivery, can be traced to several characteristics of their occupation and to problems in the design and implementation of training programmes.

*1. Training:* Most TBA training programmes do not understand or address the motivation of TBAs or their ability to learn. The typical TBA is not convinced that her way of doing things is inadequate; TBAs and the families they serve often believe that a certain number of infant and maternal deaths are simply god's will. The demand for enhanced skill, therefore, is minimal, and training often represents not much more than a stipend and the prestige of association with a governmental programme.

Even when TBAs are sufficiently motivated to upgrade their skills, training methods are inappropriate. Training programmes are conceived, designed, and implemented by literate people. It is therefore not surprising that the training is more appropriate for literated people. Much more effort needs to be devoted to deciding on the most effective pedagogical approach for illiterate audiences.

*2. Support Systems:* It is well-established in theory that TBAs must be linked to a comprehensive health system which provides support services. In practice, TBAs have little contact or communication with other components of the health system that could confirm their diagnoses of high-risk pregnancy, serve as referral centres, or help supervise and monitor their work. In addition, when supervisors do exist they rarely treat TBAs with respect or provide support or positive reinforcement for their work; such treatment may cause support systems to break down or deteriorate.

*3. Incentives:* TBAs earn their income from delivering infants, not from referring pregnant women to other health personnel or from providing family planning services and information. In the absence of an institutionalised referral system that might lead pregnant women to demand trained care, TBAs almost

invariably attempt to deliver the infant themselves. They seek help only when they are clearly unable to handle the problem, and by then it is almost always too late.

**4. Evaluation:** Little evaluation has been conducted on the strengths and weaknesses of TBA training programmes, and particularly on whether the skills and information being taught are actually applied. As a result, changes are rarely made in programmes that could improve their quality and effectiveness.

Examples certainly exist of TBAs who have improved their skills and helped reduce maternal mortality and morbidity. Such successes, however, are achieved only when the constraints listed above are overcome. In a context characterised by the absence of support services, lack of conviction among TBAs concerning the inadequacy of their traditional skills, and skewed economic incentives, the best service that can be done for mothers at risk of pregnancy related complications is for governments to make the necessary investments in improving the general well-being of their citizens. Improving nutrition, expanding family planning programmes, increasing girl's access to education, and improving social sector services may well be more likely to reduce maternal mortality and morbidity than will ineffective TBA training programmes.

- Based on paper prepared by Dr. Samia Altaf, Development Research and Management Services, Pakistan



## **34. SOCIAL COST OF MATERNAL DEATHS**

### **ORATAI RAUYAJIN & BENCHA YODDUMNERN-ATTIG**

In countries with especially traditional societies, women whose biological function is to reproduce the species have a significant role in motherhood, and their social status is based on their abilities to fulfil this role. Generally, childbirth is a joyful event for a family and community. Yet safe motherhood has long been neglected by policy-makers as an important prerequisite for national development. Consequently, many thousands of such mothers have been dying in developing countries.

As far back as 1942, Thailand's Ministry of Public Health was concerned about maternal mortality and established a Maternal and Child Health Division within its Health Department; this Division was later renamed the Family Health Division. Its main duty was to expand maternal and child health coverage over the entire country. The basic strategy was to train auxiliary midwives to staff a number of midwifery centers that would provide expanded services at the district level.

During the past decade, the Ministry has strengthened the maternal and child health services in order to achieve maximal coverage of both curative and preventive care at all levels. The programme focused on increasing community participation and involvement to increase service accessibility and acceptability. In line with WHO's Safe Motherhood Programme, the Ministry has launched many other programmes aimed at halving the present mortality rate by the year 2000 and carried out a pilot study for improving the services through the primary health care approach, targeting high-risk and special minority groups.

In terms of the country's developmental future, the maternal mortality rate is still high and is one of the leading causes of death. This is especially the case for women living in remote rural areas as well as among the minority Muslim population in southern Thailand. These mothers represent the vulnerable groups in need of immediate interventions, since they have the least access to services due to physical, social and cultural barriers.

### **MATERNAL MORTALITY**

A one-year nationwide survey of maternal mortality collected data in 1989-90 from medical records and death certificates about mothers who died in hospitals, clinics, health centres and other health service units run by the

government and private organizations. Results showed that the nation's maternal mortality rate was 2.7 per 1000 live births, but this varied depending on the region under study. The highest rate was in the south (5.0 per 1000 live births) and the lowest in the central region (1.1 per 1000 live births). Most maternal deaths in the south came about because the mountainous terrain restricts access to government health services. Furthermore, certain traditional childbirth practices are inappropriate, and many mothers are attended by traditional birth attendants and had no antenatal care.

The social costs of maternal mortality are enormous, but they fall most harshly on a women's traditional role of mother and on the children under care. An old Thai proverb reflects the consequences of maternal Mortality. It says, "Without a father, a child's life will be hard; it will have no direction. Without a mother, the situation is even worse-the same as a sinking boat or broken ferry."

Traditionally, a child whose mother died in childbirth was adopted by the mother's relatives. Older children (around 12 years of age) would care for themselves and any younger sisters and brothers. However, in times of need, mother's kin group provided a secure base from which to tap needed resources. As a result fostering arrangements and orphanages were not necessary.

In contemporary Thai society however, low fertility has led to small family size, an increase in the number of nuclear families, and a reduction in the role of kin groups. The impact of maternal deaths, therefore, is greater today than in the past. Orphans have fewer people to turn to, and many must be cared for society. Others enter the workforce early and earn their living as factory workers; still more become "street children". These youngsters are uneducated homeless and are often forced to become beggars to eke out their living. To deal with their hardships, many turn to drugs, and this results in various types of social problems including increased juvenile crimes and prostitution.

## **AIDS ORPHANS**

This situation is worsening as Thailand comes under the grip of the AIDS epidemic. More women and children are becoming HIV-positive as the disease begins to afflict low-risk groups such as housewives and factory workers. For every pregnant woman who is HIV- positive, her child has a one-in-three chance of also contracting the disease. Those children who are afflicted will die within two to five years.

In large cities such as Chiang Mai in northern Thailand, where the HIV-positive and AIDS rates are high concerted efforts are being made to address this problem. One method is to establish home care for HIV-positive and AIDS

orphans. Instead of living in a hospital with its sterile, insensitive environment, such children without mothers are transferred to home that provides better quality and more compassionate care. Without doubt, as maternal mortality increases from AIDS, this type of home will be in greater demand in the future.

Some orphans, who are not fortunate enough to receive home care, are often seen as a burden to their families. In a large Bangkok slum, about 35 to 40 orphans live among the spreading AIDS situation and the social problems brought on by overcrowded conditions and poverty. Fostering arrangements and orphanages are thus in growing demand.

So maternal mortality attacks the very heart of family's future, not only in terms of child care but also of economics. Women make up about 69% of Thailand's labour force. Rates of premarital sex, pregnancy and abortion are also very high among this group, which places them at greater risk of contracting AIDS, transmitting it to their unborn child and later dying from the disease, only to leave another AIDS orphan in society's care. The future picture of maternal mortality in Thailand, therefore, is one of uncertainty, and will no doubt influence the nation's ability to expand and enter into the industrialized world.

The impact of maternal mortality on the individual, the family and society at large is like a pebble dropped into a pond, where the ripples of action and reaction reach out to all shores. In Thailand, the problem is causing particular concern. If a society does not have an adequate mechanism to manage or absorb the costs, and most importantly to care for the children involved, each person's and the society's quality of life will decline as will their health, livelihoods and the nation's developmental prospects.

*=From: WORLD HEALTH, VOL 46. NO:3 May - June 1993.*



## 35. FERTILITY AND FAMILY PLANNING IN THE FUTURE

Infant and child mortality rates are falling primarily because medical prevention and treatment programs are helping to control the major causes of death. But rising levels of education for women, better health care practices, and more use of treatment facilities and family planning services also have played important roles. Future gains in child survival will require that programs for disease prevention and treatment and also family planning programs reach out to serve more disadvantaged, rural families.

What are the prospects for further fertility declines in the developing world? What role will family planning programs play?

Researchers have offered a variety of explanations for fertility declines. Some have pointed to the role of economic and social development in promoting preferences for small families as the value of children to their parents changes. Others have emphasized the power of new ideas and values-the ideational factor-in changing people's reproductive attitudes and behavior.

One view of fertility decline emphasizes the diffusion of innovation-the process by which use of family planning and resulting lower fertility spread from one special group or geographic area to other groups and areas. In support of this view, surveys show that fertility typically has fallen first among economically advantaged, high-status, educated couples living in cities and later has spread to the less educated, more rural masses. In a country that has few barriers to this diffusion, fertility can decline rapidly. For example, lower fertility quickly spread throughout Thailand because the large majority of Thais share a common culture that is open to change and because most rural areas are linked to the national economy.

Studies also have documented the important role that family planning programs play by supplying modern methods of contraception. Strong family planning programs enable fertility to fall faster than it would otherwise both because they encourage people to want smaller families and because they provide the means for couples to achieve their desires. W. Parker Mauldin and John Ross find that family planning programs and socioeconomic development each played an important role in reducing fertility rates between 1975 and 1990. Their study agrees with the earlier findings of Mauldin and Robert Lapham that strong national family planning programs lowered fertility independently of socioeconomic setting between 1965 and 1980.

An important implication of these studies is that strong family planning programs can encourage contraceptive use and lower fertility even if a country

is not developing rapidly. For example, fertility declined in Bangladesh from a TFR of about 7 children per woman in 1970 to 5.5 in 1991. the use of contraception rose from only 3% of married women in 1970 to 40% in 1991. These changes occurred despite the fact that Bangladesh is one of the world's poorest, most traditional, agrarian countries, where the infant mortality rate is high, women's status is low, and most families still depend on their children for economic security. The Bangladesh national family planning program, however, ranked among the 10 strongest in the nearly 100 developing countries assessed by Mauldin and Ross in 1989.

Typically, however the most effective family planning programs are in the most rapidly developing countries. Where fertility has fallen most, as in much of East Asia, Strong government support for family planning has combined with rapid development and changing social values to promote the widespread use of effective contraception.

On balance, the pace of continued fertility declines is likely to depend on three related factors: (1) how fast societies develop; (2) how quickly new norms concerning small families and use of family planning spread; and (3) how well public programs and private suppliers can meet the growing demand for contraception.

In many surveyed countries much of the potential demand for family planning is not being met. This unmet demand amounts to more than an estimated one woman in every five. In most surveyed countries not only is the use of family planning less common among less educated, rural women than among better educated, urban women but also a larger share of the potential demand for family planning is unsatisfied among less educated, rural women. This gap is clear sign that access to services is unequal and that family planning programs need to extend their reach.

If the potential demand for family planning expressed in surveys were fully met, contraceptive prevalence in the developing world would increase from 51% to more than 60%.

Such an increase in prevalence would reduce fertility levels by an estimated average of about one child per woman and perhaps more. If programs met all potential demands fertility in developing countries would fall from an average of 4 children per woman to 3.

*Source= Pop Reports M-11 Dec 1992.*

### **36. ACCELERATING THE STRATEGIES FOR INCREASING THE USERS OF CONDOM (A Case Study)**

The faculty of the Gandhigram Institute of Rural Health and Family Welfare Trust TAMILNADU worked in 2 subcentres in Vadipatti Primary Health Centres, Madurai district in 1984 for a period of 2 years.

Community involvement and establishing depot-holder through their choice was salient feature. Separate meetings were conducted for small groups of men and women with the co-operation of peripheral level workers in all the villages and on an average one male and one female depot-holder for every 100 households was established. The depot-holders were petty shop-keepers, barbers, tailors, noon-meal scheme workers, Balwadi teachers and other sociable acceptable persons. The workers were given training to carry out this work systematically.

In the beginning of the programme the acceptance rate of condom was 3.12 percent. This was increased to 15 percent. This Experience showed that with proper approach and motivation the spacing methods can be promoted very effectively and efficiently.

Source: Action Research to promote the use of condom in rural areas; Bulletin, GIRH&FWT. Vol. XXI No.3, Dec. 1986.



## 37. INDONESIA EXPLOITS IT'S OWN SUCCESS (A Case Study)

“We have reduced the birth rate very rapidly since 1970 and now we intend to do the same thing for maternal mortality” says Dr. H. Nardo Gunawan Director of Family Health Indonesia.

The nation-wide people's welfare movement have been taking primary health care and family planning information into the villages through mother awareness group, are now introducing maternal health activities including home-based maternal record cards.

Religious leaders in Indonesia have played a major role in spreading Koran's messages in favour of family planning. They are now called for to the challenge any negative attitude towards women's health and to emphasise the Koranic Saying 'Heaving is in the soul of the mother'.

*Source: Safe motherhood WHO issue - March - June 1990.*

### Importance of Safe drinking water Source

Diseases resulting from the ingestion of pathogens in contaminated water have the greatest public health impact worldwide. The current global cholera pandemic can only be resolved through the introduction of safe drinking-water supplies and appropriate levels of hygiene. Diarrhoeal diseases are among the leading causes of morbidity and mortality among children under five years of age - 1 600 000 000 cases with 3 200 000 deaths per year. These diseases are usually caused by water-borne pathogens such as Salmonella, E. coil, Shigella, and enteroviruses.

## 38. THE HOME-BASED MATERNAL RECORD- AN APPROPRIATE TECHNOLOGY

The concept of 'Home Based Maternal Record' is similar to the child's growth record such as the 'Road to Health' Card and is an appropriate technology for use by primary health care workers to record information on pregnancy, absence or presence of high risk conditions. In communities with illiterate health care workers, a pictorial HBMR is most suitable.

An evaluation on the use of HBMR by WHO in twenty centres in fourteen countries, make it clear that women and health workers found the HBMR system a useful one that promotes mothers and families participation in self care. Primary Health Care workers identified risk factors more fully by HBMR. Experiences from two countries reported some problems as too many women were classified as 'at high risk' depends upon the health status of women and the capacity of existing services, the 'cut off points' be selected very carefully by Health Professionals, appropriate to the community setting.

The evaluation further showed that more than two thirds of women kept HBMR safe in all studies and that once the health workers became familiar with the HBMR, it required less effort on their part to maintain it than previous system of records.

*Source: 'Mothers and Children' Bulletin Vol.10, No.1, 1991 Nutrition Clearing House, American Public Health Association, Washington, U.S.A.*

## 39. WOMEN'S NUTRITION

Women suffer more than men from iron deficiency anemia, from stunting caused by protein-energy malnutrition, and from iodine deficiency. Iron deficiency anemia, affects 458 million adult women against 238 million men. About 450 million women are stunted because of protein energy malnutrition compared with 400 million men. Iodine deficiency also affects substantial numbers of women, probably more than for men. Corneal lesions and blindness caused by vitamin A Deficiency afflict both sexes equally, but deficiency as such is twice as common for girls as for boys. Women's nutritional problems are worst in South Asia, where prevalences of anemia, protein-energy malnutrition, and vitamin A deficiency are the highest in the world and where, as a result of widespread discrimination, girls and women suffer disproportionately.

Small pelvic size among stunted women increases the risk of maternal and infant mortality. Iodine-deficient mothers give birth to more infants with cretinism and other congenital abnormalities. A significant proportion of pregnancies end in poor maternal or infant health as a direct consequence of maternal malnutrition.

Iodine and vitamin A deficiencies tend to be localized rather than widely distributed and could be virtually eliminated through targeted, sporadic interventions, given a reasonable health infrastructure and a high level of political will. Anemia and protein-energy malnutrition, by contrast, affect much larger numbers of women and require more continuous intervention. Distribution of a regular supply of ferrous sulfate tablets can prevent or cure anemia among pregnant and lactating women. Such efforts should include all women of reproductive age, certainly where the prevalence of anemia among women in general exceeds 50 percent. To reduce protein energy malnutrition, much must be done outside the health sector toward making more food available to households, increasing employment opportunities for women, decreasing the time and energy costs of women's home production, and reducing discrimination against women and girls.

*Source: WORLD DEVELOPMENT REPORT : 1993.*



## 40. MAKING PREGNANCY AND DELIVERY SAFE

Under optimal conditions about 990 of every 1,000 pregnancies that reach the seventh month of gestation conclude with a healthy newborn and a healthy mother. For most women in the developing world, however, childbirth is unsafe. About one in 50 women in developing countries dies as a consequence of complications of pregnancy and childbirth, compared with only one in 2,700 in the established market economies. Maternal mortality has profound consequences within the house hold; the chances of dying for children under 5 increase by up to 50 percent when the mother dies.

In 1987 the international health community, including the World Bank, WHO, the United Nations Population Fund (UNPF), and agencies in forty-five countries, launched the Safe Motherhood initiative. The prime goal is to reduce by half the number of maternal deaths by 2000. The health programs recommended under the initiative include family planning and pregnancy related care, prenatal care, and delivery care. The marginal cost-effectiveness of pregnancy-related care varies with circumstances, but the World Bank has estimated that the average cost per DALY is between \$30 and \$110, the equivalent of less than \$2,000 per death averted.

The extension of prenatal, delivery, and postpartum care to 80 percent of the world's population would reduce by 40 percent the burden of disease associated with unsafe childbirth, at a cost of between \$90 and \$255 per birth attended, or \$4 to \$9 per capita. A reasonable program of pregnancy-related care would include three components:

- \* Information, education and communications designed to create a demand for clinical services, alert women and others to danger signs that may occur during pregnancy and childbirth and mobilize communities for transport of women with complications to district hospitals.
- \* Community-based obstetrics with trained nurse-mid-wife staff to provide prenatal care, including tetanus toxoid immunization, treatment for syphilis, provision of micronutrients (iron, folate, and iodine) and detection of complications of pregnancy and delivery; normal delivery, sedatives for early eclampsia and manual removal of the placenta; effective early referral of severe complications; and safe abortion.
- \* District hospital facilities to provide essential obstetric services (cesarean section, anesthesia, blood replacement, manual procedures, and monitoring of labour) and neonatal resuscitation (aspiration of secretions and assisted respiration with oxygen).

The emphasis given the different components will depend on local conditions. At one extreme are districts where resources are limited and women are highly isolated. Here, high priorities would be prenatal care aimed mainly at correcting micronutrient deficiencies and infections such as STDs and malaria. At the other extreme are urban and periurban areas where referral centers are overwhelmed with normal deliveries and the quality of care is typically low; here, health centers should be improved so that they can deal with normal births, and the quality of hospital care should be enhanced to provide better treatment of obstetric complications.

**NOTE: DALY IS DISABILITY ADJUSTED LIFE YEAR**

*Source: WORLD DEVELOPMENT REPORT, 1993*

## 41. FEMALE INFANTICIDE

In Morappankadu (Salem District, Tamilnadu) on October 16th, 1992 a mother gave birth to twins. She had daughters already. Two days after their birth, the twins were dead allegedly through starvation and given an unceremonious burial.

This is one of the many incidents occurring in many parts of TAMIL NADU and possibly in many other parts of India. Community Services guild of MADRAS and ADITHI, a patna based organisation for Welfare of Rural Woman has studied this problem. ADITHI says that nearly half of the female children born in some areas are killed within a week of their birth, Just to avoid the expenses of rearing the female child and later to give her away in Marriage with a dowry.

The mothers of these girl infants did not feel they were doing an injustice to their daughters by this action.



## 42. CHILD LABOUR

The Problem of Child Labour is principally one of Poverty and Unemployment. Economic compulsions weigh heavily on the decision to send their children to labour in Match factories, fireworks factories, in foundaries in villages and small towns and in other hazardous industries and activities.

The constitution of India, prohibits exploitation of children and commits the nation to ensure the Welfare and protection of children against exploitation and harm.

The Children (Pledging of Labour) act, 1933 prohibits a parent or guardian from pledging the labour of a child.

The employment of Children Act, 1938 prohibits employment of children in hazardous industries, injurious to health.

The factories Act, 1948, prohibits the employment of children below the age of 14 in factories and lays down conditions for employment of children between 15-18 years.

There are similar acts to ban the employment of children in bidi and Cigar manufacturing, in shops and establishments, in Motor mechanic workshops etc. 1981 (Census) of India reveals that nearly 14 million children were in employment. Many researchers in this field feel this to be a gross under estimate and estimate that the real figure can be 3 to 5 times than this.

Some of the jobs are gender specific. More Boys work in hotels, teastalls, furnaces, Shoe Shining, Car, Scooter repair shops. While girls outnumber in weaving, match and fireworks, agriculture, bidirolling etc. Where Boys and girls do the same work, girls get paid lower.

Social development only can reduce Child Labour as this is now embedded in Poverty and unequal distribution of assets. Child Labour may in fact be a substitute to Adult labour which is costlier. This is especially the position in industries like glass manufacture, gemcutting, Quarries, fireworks. But in many cottage industries, it is a supplemental income for the family as the child will be even otherwise be in the house. Effective implementation of Universal Schooling upto Tenth Standard can curb this Child Labour operating from the house. This demands peoples' participation in seeking quality education to their children.

## 43. THE WORLD SUMMIT FOR CHILDREN

The declaration and plan of action adopted at the World Summit for Children, held in New York in 1990, incorporate a politically salient agenda for health. The summit focused, in particular, on the needs of children and women but was set in the broader context of human and community goals. The seventy-one heads of state who attended and the seventy-seven more who subsequently signed the declaration committed their countries to developing national programs of action (NPAs) for achieving these goals. To date, about eighty-five countries have drawn up NPAs, and an other sixty are in the process of preparing them.

NPAs typically cover, among other concerns, primary health care, family planning, safe water, environmental sanitation, nutrition, and basic education. Because of their concentration on the welfare of children, NPAs are able to transcend political differences. They offer a means of mobilizing the whole of civil society - neighborhood and civic associations, religious groups and professional bodies, businesses, voluntary agencies, organized labor, and universities- in the cause of investment for health.

NPAs are being integrated into national development planning. They set forth measurable, attainable goals-to be met by 2000 or earlier- that are adapted to the realities of the country. By quantifying the resources required to achieve these goals, NPAs help to identify the changes that are needed in national budgets and external aid if priorities for human development are to be met. The health goals of the summit's plan of action include:

- \* The eradication of Polio by 2000
- \* The elimination of neonatal tetanus by 1995
- \* A 90 percent reduction in measles cases and a 95 percent reduction in measles deaths.
- \* Achievement (by 2000) and maintenance of at least 90 percent immunization coverage of one-year-old children, as well as universal tetanus immunization for women of child bearing age.
- \* A halving of child deaths caused by diarrhea and a one-quarter reduction in the incidence of diarrheal disease.
- \* A reduction by one-third in child deaths caused by acute respiratory infections.
- \* Virtual elimination of vitamin A deficiency and iodine deficiency disorders.

- \* A reduction in the incidence of low birth weight (2.5 kilograms or less) to no more than 10 percent
- \* A one-third reduction from 1990 levels in iron deficiency anemia among women.
- \* Access for all women to prenatal care, trained attendants during childbirth, and referral for high risk pregnancies and obstetric emergencies.

*Source: WORLD DEVELOPMENT REPORT - 1993*



## 44. SUCCESSFUL NATIONAL IMMUNIZATION PROGRAMME SRILANKA (A Case Study)

According to a WHO release, Sri Lanka is likely to be the first developing country in Asia to eradicate poliomyelitis, the total incidence of this disease having fallen from 153 cases in 1979 to 16 in 1984 (the last year for which full information on immunization is available.)

The survey carried out by a tripartite team comprising experts from the Government, WHO and Unicef has reported over 90% of immunisation coverage for children against five of the six targetted diseases- a level that exceeds those found even in a number of developed countries'.

The success in Immunization Programme by effectively reducing the dropout of children from I to III doses of DPT can be attributed to the following key strategies-

- The political commitment of the country's leaders
- The successful integration of immunization with the maternal and child health services.
- The ANM/ Female Health Worker who is the best advocate of immunization and initiates action for covering all the children in her area by keeping a complete up-to-date record of all children in the villages.
- The literacy level of 80% of Sri Lanka women is another notable factor which has contributed to Sri Lanka's achievements in child health.

*Source: SERAB Bulletin Vol. II No. 2 & 3 July 1987 Bangalore, India.  
Reference- Evaluation of the Strategy for HFA by 2000 Vol. 4 WHO.,  
SEARO*

## 45. AN EXPERIMENT ON COMPREHENSIVE MCH PROGRAMME FOR PLANTATION WORKERS IN SOUTHERN INDIA -U.P.A.S.I. THROUGH LINK WORKERS

The experience of U.P.A.S.I. for over fifteen years concludes the following:

1. A link worker ( a voluntary health worker from the same community without remunerations) is an appropriate approach towards community participation.
2. The link worker can effectively manage no more than 20 families.
3. Female link worker can make considerable contribution in Maternal Child Health and Family Welfare Programme.
4. Frequency of meetings between link workers, health personnel and the management (project staff) should be minimum once in a month.

The impact of this approach is reflected in the statistics related to Maternal Child Health and Family Welfare. The Antenatal Service coverage could be raised to 98% and deliveries by trained personnel more than 90% compared to 42% and 20% respectively in 1971. The Infant Mortality Rate reduced from 119/1000 LB (1971) to 49/1000 LB in 1984 and the crude birthrate from 40/1000 to 22/1000. The Couple Protection Rate showed an increased from 9% in 1971 to 49% in 1984. A remarkable feature is the acceptance of sterilization by mothers with two female children or a single male child.

*Source: Ford Foundation - Anubhav Series - 1987.*

## 46. INTEGRATED MANAGEMENT OF THE SICK CHILD

Four groups of infectious disease-diarrheal diseases, acute respiratory infections (ARIs), measles, and malaria-account for more than half of the 12.7 million deaths every year of children under age 5. In the developing world measles alone causes 860,000 deaths in children under age 5 and accounts for 6 percent of DALYs lost in that age group. Malaria causes 4 percent of the disease burden in the under-five group. Sick children taken by their mothers to health centers for diarrheal disease and for ARIs such as pneumonia often receive inappropriate diagnosis and treatment, leading to unnecessary complication and deaths.

Whereas preventing diarrheal diseases and ARIs has proved difficult and is probably not cost-effective, case management in community-based programs is feasible and extremely effective. WHO and UNICEF have recently begun to support national program on the integrated Management of the Sick Child. This initiative builds on more than fifteen years of experience with case management of diarrheal diseases, mainly by oral rehydration therapy (ORT), and about seven years of research on and program implementation of case management of ARIs.

In Nepal a controlled intervention trial that relied exclusively on indigenous community health workers (CHWs) to detect and treat pneumonia without hospitalization led to a 28 percent reduction in the risk of death from all causes by the third year of service. Additional benefits were obtained from the reduction in deaths caused by diarrhea and measles. Other research on similar community-based strategies for children under age 5 indicates decreases of approximately 50 percent in infant mortality from ARIs.

In Egypt the use of ORT has in some areas led to a reduction of 50 percent in mortality from diarrhea and 40 percent in over all mortality among children age 1 month to 5 years. The experience with these two disease clusters can be expanded to include children with malaria, measles, and malnutrition. Evidence that malaria and pneumonia overlap in their clinical presentation and can be treated with the same antibiotic strengthens the case for treating several diseases together.

Under the integrated management approach, the sick child is initially assessed by means of a limited range of questions and observation of easily recognised symptoms. The child's nutritional and immunization status is measured, and immunization is given if needed. The child's condition is classified according to disease grouping and severity guidelines, which are used



as a basis for treatment and possible referrals. The final step is to give the mother advice on follow-up care.

The core of the package is to train primary health care providers to diagnose diseases and prescribe the appropriate treatment at the health center level or refer immediately to a district hospital those cases with complications. An adequate supply of antibiotics, antimalarial drugs, and other drugs is critical for success.

The integrated cluster of treatments, including hospital services, would cost between \$30 and \$100 per *DALY* saved. Since the walk-in component accounts for approximately 60 to 70 percent of the reduction in the disease burden, district hospitals are not indispensable for starting the program, but their presence and proper functioning add substantial health benefits. If high rates of health service use can be achieved, child deaths in high-mortality communities, according to WHO estimates, could be reduced by between 50 and 70 percent. This fact and the relatively low technology involved make the management of the sick child a high priority in countries with child mortality rates of more than thirty deaths per 1,000 children under age 5.

*SOURCE: WORLD DEVELOPMENT REPORT, 1993.*

## 47. AIDS AND YOU : AN INDIAN POINT OF VIEW

*Khorshed M. Pavri\**

*To remain free of AIDS, you need to understand it*

To most of us, the most important issue concerning AIDS, is how we and our loved ones can keep away from contracting HIV infection and AIDS. In order to remain free from aids you need to understand it. You need to know how you can get HIV infection so as to prevent it from happening.

During 1984-85, you were either unaware or aware but sanguine since you thought no such Western type of disease syndrome could occur in India. Later, you read about few unfortunate female prostitutes who were found to be seropositive for HIV although they showed no symptoms of AIDS. To the majority of you, this was new but of no direct concern; after all, you don't frequent such places. There was of course, much talk and advice and the public health authorities did show some concern.

### QUARANTINE OF SEROPOSITIVES AND ARISING ISSUES

The girls were quarantined (restrained) in remand homes. There, they not only continued to remain asymptomatic but showed improvement in their general health. To most of you, this might have seemed to be and still is the best solution; you did not allow certain embarrassing issues to arise in your mind(s). Only few might have spared a thought to the major issue of human rights. Perhaps you did not realise the gravity of the situation. Today's figures in 'tens and hundreds' may turn into 'thousands' of seropositives within months. How can you keep a continuous restraint on individuals who have committed no big crime? The question is how many and for how long can you quarantine? Who bears their expenses? Reality caught up with the events and most of the unfortunate girls were released, perhaps to take up where they left off. Did any of you give a thought as to how these women got infected? What about many men who might have given or contracted the virus to and from them? Some of you in Public Health did talk of serosurvey among long-distance truck drivers. A logical thought which is corroborated by findings from countries like Uganda ('World Health', March 1988; p.20) Nothing however seems to have been done about this.

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More recently, you must have read about an HIV seropositive voluntary blood donor who was incarcerated under quarantine as per a certain State's legislative requirement. We read of this incident much more because the media emphasised the important issue of human rights. (Could it be because a man was involved and not a female prostitute?) Later, we were informed by the concerned health authorities that this legislation was introduced as an important preventive measure since only foreigners were suspected to be infected with the AIDS virus. This was unfortunate as by then, indigenous cases of AIDS though few were being recognised in the country and one was especially singled out by us in the Editorial 'A Horse Has Bolted'. (Care Calling, Vol.1, No.2, of July-August, 1988).

## **SEXUAL TRANSMISSION OF HIV/AIDS**

By now, you were aware in a general way that AIDS is transmitted sexually; but you were not much troubled as you were neither a homosexual nor did you go to prostitutes.

Most of you felt safe as you were having sex mainly with your spouses or known partners. Perhaps a few went in for anal intercourse where the rectum gets much readily damaged, thus helping HIV transmission if partners were virus infected. A few of you who might have gone abroad and had intimate sexual contact there, might have had some sleepless nights. Perhaps, you should have got yourself tested for HIV antibodies.

Those with other sexually transmitted diseases (STD) such as genital ulcers, gonorrhea, syphilis, herpes and chlamydia should have been warned by doctors to take care. If you had sex with HIV-infected partners, you could be very vulnerable to contracting HIV infection/AIDS.

## **THE FIRST CASE OF AIDS IN INDIA AND THE PRESS PUBLICITY**

Soon, you learnt about the first case of AIDS in an Indian who died in a Bombay hospital. Some of you from the Press went overboard in publicising details which should have been kept confidential. This AIDS patient was a victim of human immunodeficiency virus (HIV) which was passed on to him with blood transfusion during a cardiac surgery in the U.S. At the time, there was no screening of blood for AIDS even in the US.



## **TRANSMISSION OF HIV INFECTION AND AIDS THROUGH BLOOD TRANSFUSION**

You thus learnt about the other risk factor, viz., transmission of HIV through transfusion with HIV- infected blood/blood products. Unfortunately, in the wide publicity given in the mass media, some element of disingenuity crept in which led to much misunderstanding.

The virus of AIDS was indeed the culprit but the unfortunate victim appeared to be 'Blood Donation'. Many blood banks began to experience a symptom of AIDS, i.e., loss of weight in their blood donations.

The supply was drying up because of some well-meant misinformation. The situation was saved through the intervention of some highly respected and responsible personalities associated with blood banking.

The following points were made clear at that time, and need to be reiterated:

### **BLOOD DONORS AT RESPONSIBLE BLOODBANKS ARE AT NO RISK OF ACQUIRING HIV INFECTION**

Responsible blood-banks means those which strictly follow all the known good practices and which always use freshly sterilised or new (if disposable) needles and other equipment for collection of blood.

- \* Every voluntary donor has a right-I say, a duty-to see that all the required good practices are strictly adhered to during blood donation camps or in hospitals and blood banks.
- \* Paid or professional donors- openly, or in the guise of replacement donors-would of course be unable to demand such a treatment.

### **BLOOD RECIPIENTS ARE AT RISK OF GETTING HIV-INFECTION AND AIDS DEPENDING ON:**

Where the hospital/blood bank is located and the nature of practices it follows regarding selection of blood- donors and for collection, storage and screening of blood.

The risk would be greater if the blood obtained is from donors who sell blood as their main livelihood. Such persons are known to be infected with hepatitis B virus and often suffer from one or more STD as well.

You must now be well aware that antibodies reacting to HIV-1 have been detected in a large number of commercial blood donors especially those used

for indigenous manufacture of blood products as reported in CARC CALLING (Vol.2, No.1. January-February, 1989). Despite many press reports professionals from the medical and related fields and from blood banks have remained rather silent.

Should they not speak out as individuals, preferably as Associations and help and guide the Government authorities in framing feasible guidelines for safety of blood/blood products?

## **AIDS IN INTRAVENOUS (IV) DRUG-USERS**

In the US and several Western countries, sharing of HIV contaminated syringes and needles by IV drug users is an important risk factor for getting AIDS. Recently, with homosexuals voluntarily changing their behaviour and life-style, the drug-associated spread of HIV and AIDS is gaining significance.

We have an increasingly large number of drug addicts, particularly, among the youth and adolescents. You and I do not know the extent of the use of intravenous injections among them but should we not make every possible effort to find out before it is too late.

Are you aware that Thailand is recently experiencing a frightening increase in the infectivity rates (as estimated by seropositivity to HIV) among their intravenous drug abusers? There was a spurt in seropositivity from 1% recorded in late 1987, to 15% in March 1988, and to 43% in August 1988. Its impact will unfortunately be much more since many of these IV drug users are known to donate blood.

Reports are now coming from the USA that 'crack' a smokable form of cocaine hydrochloride may become another risk factor for AIDS. If the preliminary reports are confirmed, we in India may also start seeing the spread of HIV infection among drug abusers.

## **IF DRUG-INJECTIONS CAN CAUSE AIDS CAN MEDICAL INJECTIONS BE FAR BEHIND?**

Have you considered the possibility that transmission of AIDS could also occur through medical injections in the same way as for IV drug injections, if contaminated needles and syringes are used again and again? Medical injections play important role as a source of spreading AIDS in Africa. You may be right in thinking that the situation is not as bad in India, because so far, we have little virus going around. But, for how long do you think this situation will remain the same?



When serosurveillance was initiated in India, only a small number of female prostitutes was detected to be HIV seropositive. Now the number of seropositives has increased and includes more than 200 seropositive males the majority tested from the STD clinics.

Let us not repeat through injections using contaminated needles or syringes, what seems to have occurred among blood donors employed by manufacturers of blood products in India. Somewhere in some place at a (blood product) manufacturing unit(s), at some time in the recent past, HIV infection has spread from one infected donor to several uninfected ones through the use of the same contaminated equipment. Should we wait till a similar incident may occur in our STD or TB clinics or in our hospitals?

## **GREATER RISK OF SPREAD THROUGH PROMISCUOUS MALES**

Female prostitutes, I am told, generally go to private doctors including STD specialists. They generally do not donate blood. In contrast, promiscuous males do frequent public STD clinics and out-patient departments of hospitals. Several of them may be paid blood donors. Thus, they are more likely to spread HIV infection not only sexually but also through blood transfusions and injections. They are now in hundreds; soon, they will be in thousands. How many of these men do you think can be quarantined or detained for our safety and for how long?

**Therefore, the most important strategy is prevention through health education beginning immediately with adolescents and youth. (CARC CALLING 1 (3): 7-10-1988).**

## **PERINATAL TRANSMISSION, I.E., FROM INFECTED MOTHER TO HER OFFSPRING**

You would have been more concerned that so many prostitutes were seropositive if you knew they could pass the HIV infection to their children. This could happen before the baby is born or during or after birth. The issue is debatable but it is believed that 25% to 50% of children born of HIV seropositive mothers are infected with HIV. Serosurveillance among mothers in the antenatal period is being undertaken in India.

There is however, a need for the development of more appropriate diagnostic technology before we attempt to determine accurately the extent of the spread through perinatal transmission.



## **YOU CAN'T CATCH AIDS LIKE YOU CATCH COLDS OR TYPHOID**

HIV-infected children do not normally pose any threat to you because they neither belong to sexual nor to blood donor risk groups. Your children will not get HIV infection from them in schools like they catch colds, mumps, measles. You will not even get AIDS from infected persons- adults or children - by hugging or kissing them.

You are not likely to catch the infection through saliva, sweat, tears, urine or stool. The virus of AIDS is not transmitted through food or water. In fact, the virus of AIDS is much less infectious than so many others, including hepatitis B virus.

## **INSECTS AND AIDS**

Much has been written about the role of mosquitoes or other blood sucking insects in spreading AIDS, particularly, in countries of Africa where environmental factors are shown to be important. You might also have wondered why bed-bug and mosquito bites should not be considered a possible modes for spreading HIV infection. The question of insects has been discussed in detail to show that insects do not have a role in the spread of HIV infection.

## **BLOOD -TO BLOOD TRANSMISSION OF HIV AND AIDS**

If you don't have to worry about insect and if you are sexually all 'good boys and girls', your only worry would be to prevent blood to blood transmission either through infected blood transfusion or through contaminated needles and syringes.

In general, you may like to avoid taking unnecessary injections or ill advised blood transfusion. Therefore, you would like your doctors to be careful and cautious in prescribing these, and also consider safer alternatives. However, you may not escape these completely. Blood transfusion may be the only hope for survival for accident victims or for young mothers with post-partum hemorrhage. I am sure you would like to have your source of blood free of HIV infection. In addition to blood transfusion and use of contaminated needles, large bleeding wounds after accidents, blood spurting during surgical or dental procedures, or wherever a large amount of HIV-infected blood is likely to get into your blood-stream, should be considered as a potential danger.

All the necessary care and precautions should be taken by all professionals, coming into contact with HIV-infected blood.

*SOURCE: CARC CALLING:*

**Time to Act Against AIDS  
WHO Regional Director's Message  
for World AIDS Day - 1993**

In the past one year, AIDS has spread its tentacles even further, globally. It is estimated that 5000 people are being infected every day with the human immunodeficiency virus (HIV). In Africa, Latin America and Asia, the number of new infections had increased considerably in the past year.

Since the epidemic began, some 14 million people have been infected and over 2.5 million have developed AIDS. Adding urgency to the problem is the absence of any effective vaccine or drug and the prospect of the number of infections and cases multiplying several times by the year 2000.

Having recognized the threat posed by HIV/AIDS, all countries have mounted serious efforts to prevent and control AIDS through a multi-sectoral approach, stated the Regional Director.

Keeping these factors in mind, this year's World AIDS Day theme. "Time to Act", stresses the fact that it is time to fight complacency and to promote safer sex, use of safe blood and safe injecting equipment. It is also time to reduce the vulnerability of women to HIV infection and to provide young people with the knowledge and means to protect themselves from infection

## 48. WOMEN AND AIDS

### A CHALLENGE FOR HUMANITY

WHO estimates that one third of the adults infected with HIV are women. This is likely to increase by the year 2000 AD when the number of AIDS cases in women will begin to equal that in Men.

HIV infection in Pregnant Woman with implications for Perinatal infection and elevated infant Mortality will have a devastating impact on the fabric of Society. The Death of Women in reproductive Age group will leave their Children not only as Motherless but as Orphans as Most probably its father is also HIV infected and has developed AIDS. The Number of such orphaned children will be many Millions.

The Status of women within the family and society makes them particularly susceptible to HIV infection, a "SOCIAL VULNERABILITY" related to their generally low Status. Many women have no access to information on HIV and how to protect themselves from HIV infection. The Stigma attached to AIDS can subject her to discrimination, Social rejection and other violations of their rights.

The challenge is therefore to meet the Priority Health needs of women in the participation of women themselves, as well as women's Organisations



## 49. HIV INFECTION IN PREGNANCY AND PERINATAL TRANSMISSION

*Dr. Jayashree V. Joshi\**

The epidemiological distribution of AIDS has undergone a change. Initially AIDS was reported commonly in homosexual men, intravenous drug users and recipients of infected blood. However during the last few years 30 to 50% of AIDS VICTIMS all over the world have been women in the reproductive age group. It has become one of the leading causes of death in women aged 15-44 years in the United States. A recent survey from several antenatal clinics in the US indicated that 1.5/1000 pregnant women were infected with HIV. In African countries like Rwanda and Uganda the prevalence of HIV seropositivity in antenatal clinics was observed to be upto 30%. In India the ICMR serosurveillance study indicates that 22.7% of AIDS cases are young women. Of all HIV seropositive persons reported in India, 49 (0.5%) were pregnant. The total number of women in the child-bearing age who may be seropositive is estimated to be 30,000. Heterosexual mode of transmission has become the most common way of acquiring this fatal disease. Whatever the mode of transmission, when a young women infected with HIV becomes pregnant she poses a dilemma to the obstetrician. The aim of this article is to briefly review current literature on HIV infection in pregnancy and the options available for its management.

### **The risk of vertical transmission**

Hira and co-workers, in a study from Zaire, placed the risk of transmission of HIV from a pregnant seropositive mother to her offspring at 39%. In their series on HIV seropositive pregnant mothers about 1/5th cases had advanced disease or had developed AIDS. Similar findings have been reported by others in studies from African population. The proportion of pregnant women with AIDS was 18% in the study by Ryder and co-workers, who have reported on 466 HIV positive and 606 HIV negative mothers. Prospective studies in Europe and the US, have however shown that the risk of vertical transmission may be much lower i.e. 15 to 29%. This may be attributable to the lower proportion (3 to 10%) of their seropositive pregnant mothers presenting with the advanced disease. Progression to the full blown disease enhances the degree of viraemia and increases the chance of vertical transmission.

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## Mechanisms of transmission and time of vertical transmission

The Primary mechanism of transmission is trans-placental. Various workers have demonstrated the virion or viral antigens like p41 and gp120 in placenta or in foetal tissues. Interpretation of some earlier studies has been difficult because contamination with maternal blood could not be ruled out. HIV was cultured from foetal brain, lung and spleen obtained from products of pregnancy at 15 weeks gestation in an AIDS patient and from term placenta. Jauniaux and co-workers showed the presence of particulate virus like material in ultrastructural examination of villous tissue, in fibroblasts, syncytiotrophoblasts and endothelial cells in products of conception from HIV infected women who underwent abortion between 10 to 22 weeks of pregnancy. Using in situ hybridization techniques, HIV antigen was demonstrated by Lewis and co-workers in foetal trophoblasts and placental villous tissue as early as 8 weeks of gestation. The virus has been isolated from cell free amniotic fluid as well as from the cells of amniotic fluid. HIV has also been shown in foetal nervous or hepatic tissue as early as 13 weeks gestation by using the polymerase chain reaction (PCR) of HIV DNA in abortuses from infected women.

Vertical transmission can occur by various mechanisms in early as well as late pregnancy. Placentitis is usually present but is not essential for transmission. Active transfer during acute viraemia, or transfer of infected maternal cells can occur at any stage of pregnancy, but more easily after 20 weeks, when placental breeches occur more frequently. These breeches are encouraged by inflammatory processes like placentitis and chorioamnionitis (e.g. Syphilis and Chlamydia trachomatis infection) and, also by mechanical trauma like operative deliveries. Evidence for transplacental transmission is provided by detection of HIV by PCR or virus isolation and culture from cord or venous blood from the infant at birth.

Direct transfer of HIV can occur during normal vaginal delivery through maternal, cervical and vaginal secretions which may have extremely high concentrations of the virus. Transplacental infection is common in later weeks of gestation and operative procedures can promote transmission through blood, hence Caesarian section has not been recommended as a preventive measure. In cases with intra-uterine or antepartum transmission of HIV, the infants show evidence of viral antigen in blood samples within 3 months of birth and develop symptomatic disease before the age of 6 to 12 months.

Those with intra-partum transmission show evidence of viral antigen after 3 months whilst tests for maternal genital secretions are positive at the time of delivery. They tend to develop AIDS after 12 months of age. Ehrnst and co-



workers conducted prospective study in Sweden on mother-infant pairs and observed that 3 infants developed symptoms of HIV infection by 6 months. One was positive at birth by PCR. The other two were not tested at birth. Five infants were negative for HIV (by isolation) at birth but were HIV positive by 6-9 months; out of these 4 were symptomless upto 18-56 months of age. In their opinion intrapartum transmission is more common than antepartum transmission of HIV.

## POST-PARTUM TRANSMISSION

HIV has been isolated from the fluid as well as the cellular histiocytic component of human breast milk. In many cases it is not easy to exclude late ante-partum or intra - partum transmission. However Ziegler and co-workers observed post-partum seroconversion of a mother due to transfusion of HIV positive blood subsequently followed by seroconversion of the breast feeding infant and development of AIDS in both. Van de Perre and co-workers conducted a long term prospective study on a cohort of mothers and infants, all of whom were seronegative at the time of delivery. Seroconversion in some mothers was simultaneously followed by seroconversion of their breast-fed infants. Viraemia at the time of primary infection during the post-partum period and absence of specific maternal protective antibodies are important contributory factors in transmission of HIV infection through breast milk.

It is known that all seropositive mothers do not transmit the virus ante-partum nor does post-partum transmission occur in all breast-fed infants. However it may be advisable to avoid breast feeding if the mother is HIV seropositive in situations where socio-economic conditions are suitable for top-feeding. In developing countries however conditions for artificial feeding are far from ideal. The risk of infant morbidity and mortality from diarrhoeas and infections in artificially fed infants exceeds the risk of transmission of HIV infection through breast milk. Moreover in cases with advanced disease or acute viraemia during pregnancy, transmission may have occurred ante- or intra-partum earlier. Hence the World Health Organisation has issued guidelines to mothers from developing countries to continue breast-feed even if they are HIV seropositive. Van de Perre and co-workers recently studied 215 HIV 1 infected women at delivery in KIGALI, Rawanda. HIV 1 IgG, secretory IgA and IgM were studied in serial milk samples by Western blot and HIV viral genome was studied in cellular component of milk by double polymerase chain reaction. They concluded that the rate of transmission is very high i.e. 47% if cells in breast milk were positive for viral DNA and if milk was negative for lgm and



IgA. Anti HIV-1 antibodies in breast milk may protect against post-natal transmission of HIV.

## **OTHER FACTORS AFFECTING PERI-NATAL TRANSMISSION**

The type of antibody response in a seropositive mother may determine peri-natal HIV transmission. Antibodies against gp 120 antigen or to the V3 loop may have some protective value. However it has been observed in twin pregnancies that one of the twins may be affected whereas the other is not. Goedert and co-workers observed that out of 50 HIV-exposed twin pairs, 25 pairs has discordant HIV status. The risk of viral transmission was higher for the first born twin, irrespective of whether it was delivered by Caesarian section or vaginal delivery. Maternal antibodies may not have a major role in prevention of vertical transmission of HIV. Discordant twins also highlight the role of genetic factors and histocompatibility antigens in susceptibility to HIV infection. Kaslow and associates have shown that the decline of T-helper lymphocytes in HIV infected individuals is more rapid in association with HLA B 8 antigen.

## **EFFECT OF PREGNANCY ON HIV INFECTION**

Pregnancy and HIV infection, both have been shown to have progressive immuno-compromising effects. It is therefore logical to expect that pregnancy may have deleterious effect on HIV infection and it may cause a rapid progression to symptomatic disease or deterioration in AIDS. CD4+ counts in blood are considered to indicate the level of immune status and counts below 400/ml are frequently reported in AIDS. In a recent prospective study Biggar and co-workers observed that CD4+ cell counts declined progressively in both HIV seropositive and seronegative pregnant women until 38 weeks of pregnancy. In seronegative women the cell counts returned to normal levels in the post-partum period, whilst in HIV seropositive women no recovery occurred or further deterioration took place. Ryder and co-workers observed high rates for AIDS and AIDS-related complex in pregnant women from Zaire. These findings were not confirmed in studies from the US and UK. Progression time to AIDS and survival time did not show significant differences between seropositive pregnant and seropositive non-pregnant women. Minkoff and co-workers reported that the number of overall infections complications were similar in HIV seropositive and seronegative pregnant women. However serious bacterial pneumonias and pneumocystic carinii pneumonias were more

common in seropositive women. Maternal deaths due to AIDS have shown an increase in the US. Low lymphocyte counts during pregnancy may indicate an increased risk of maternal peri-natal and post-natal infections as observed by Tuomala and co-workers in a serial follow up of 185 HIV infected women. They have recommended antimicrobial prophylaxis in women with  $<14\%$  CD4+ counts. However in a recently seroconverted but otherwise healthy woman who has excellent facilities for monitoring, access of preventive therapy and good ante-natal care, pregnancy may not pose an immediate serious threat.

Studies in Africa indicate an adverse effect of pregnancy on development of AIDS and deterioration of symptomatic disease possibly because of (i) higher proportion of women with advanced disease, (ii) poor quality of antenatal care, (iii) inadequate laboratory facilities for monitoring immune status, (iv) non-availability of expensive drugs like AZT and Pentamidine, (v) poor nutritional status of patients and (vi) variations in the type and virulence of HIV.

## **EFFECT OF HIV INFECTION ON PREGNANCY OUTCOME**

Data relating to the effect of HIV infection on pregnancy is controversial. Reports from African countries indicated a higher rate of premature birth, intra-uterine growth retardation and infections in HIV positive pregnant mother. Ryder and colleagues observed that the proportion of low birth weight infants was 33% with pregnant women with AIDS, 17% with seropositive asymptomatic women and 11% with seronegative pregnant women. The effect of confounding factors like malnutrition, poor ante-natal care, drug abuse and other sexually transmitted diseases could not be ruled out. Minkoff and co-workers did not observe adverse obstetric outcome of HIV seropositive mother in prospective controlled studies, although smoking, alcohol and drug abuse were independently associated with adverse outcome. Muenz and co-workers in a very well controlled long term prospective study, observed that there was no difference in 72 children born to HIV infected mothers and 82 children born to uninfected mothers in birth weight and other parameters. However babies of infected mothers who on follow up developed HIV seropositivity or AIDS had lower birth weight than those who remained seronegative throughout the follow up.

The adverse pregnancy outcome reported in African countries may depend on the larger proportion of cases with advance disease in all these studies and on other factors like sub-optimal ante-natal care or poor access to treatment. Prematurity, low birth weight, intra-uterine and intra-partum foetal

deaths were more common in HIV seropositive mothers than in seronegative mothers from Zambia, Nairobi and Rwanda

## **DIAGNOSIS OF HIV INFECTION IN PREGNANCY**

HIV infection in pregnancy can be diagnosed through routine ante-natal testing in high risk population as in some African countries. In low risk population the testing may be restricted to those with risk factors e.g. (i) intravenous drug use, (ii) associated sexually transmitted diseases, (iii) opportunistic infection, (iv) symptoms of AIDS e.g. anaemia, weakness, diarrhoea, weight loss etc., (v) HIV seropositive partners and (vi) persistent or recurrent infections.

## **MANAGEMENT OF HIV INFECTION IN PREGNANCY**

The treatment of HIV infection in the pregnant women is essentially similar to that in the non-pregnant state. However issues become more complicated due to the possibility of effects of the disease process plus the effects of drug therapies on the foetus and the availability of therapeutic abortion as an option in early pregnancy. No definite guidelines are available but the following aspects need to be considered:

1. All HIV seropositive pregnant mothers with early pregnancy should be given the choice of a therapeutic abortion in view of the potential risk of aggravation of HIV infection, the risk of vertical transmission and potential effects of drug therapy on the foetus. These effects may include growth retardation, teratogenesis, intra-uterine death, peri-natal transmission to the new-born and effects like kernicterus or cerebral palsy due to prophylactic chemotherapy. Unfortunately it has been observed that many women decide to continue pregnancy because of their own individual perceptions of risks and rights and because the risk of transmission is not 100%. However if both parents are HIV seropositive the child is likely to become an orphan within 10 years and may possibly also develop AIDS in early childhood through peri-natal transmission. Pregnant women with HIV infection therefore require good counselling services.

2. All HIV seropositive pregnant mothers, symptomatic or asymptomatic, should undergo regular evaluation, every 2 to 3 months, by a team of consultants including the obstetrician, physician and paediatrician. CD4+ lymphocyte counts and other immunological parameters or viral antigen load studies (if possible) should be conducted initially, 3-6 monthly, and at shorter intervals if any deterioration is observed.



3. HIV seropositive women having CD4+ counts less than 500/ml should be offered the benefit of preventive therapy with azidothymidine (AZT). The usual dose recommended for prophylaxis is 100 mg orally 5 times a day. It may be noted that this drug is very expensive in India and only few can afford the long term treatment. Spedrling and co-workers reviewed reports on 43 pregnant women who received Zidovudine in doses ranging from 300-1200 mg per day, and 10 women received it throughout pregnancy. Two mothers developed drug toxicity. No teratologic abnormalities were reported in 12 infants exposed to Zidovudine in the 1st trimester. There were no still-births. Two cases of intra-uterine growth retardation were reported with birth weight of 1.6 and 1.59 kg at 37 and 38 weeks of gestation. Seven new-borns were anaemic at birth (Hb < 13.5 gms %). Other contributory factors like drug abuse, sepsis and treatment with other drugs like acyclovir or nystatin were also present in these cases.

4. Those having CD4+ counts below 200/ml should be offered prophylaxis for *Pneumocystis carinii* pneumonia with pentamidine therapy or sulphamethoxazole trimethoprim combination. Although the latter combination is easily available the risk of kernicterus and cerebral palsy in the new-born is well known if treatment is given in the last weeks of pregnancy. Pentamidine therapy is currently highly expensive in developing countries and its effects on the new born are unknown.

5. No definite advantage of operative or trans-abdominal delivery vs vaginal delivery has been demonstrated, hence Caesarian section is indicated purely for obstetric reasons.

6. In socio-economic situations where top feeds can be given safely a seropositive mother may be advised not to breast-feed the baby keeping in mind the possibility of transmission of HIV through milk. In most other situations and particularly in developing countries breast-feeding is recommended. Babies are known to retrovert to the negative status depending on whether they had passive antibodies, minimal viral load or whether a large viral transmission has occurred.

7. The possibility of treating the neonates with antiviral therapy is being investigated currently. However one must recognise all these drugs as potentially toxic and hazardous.

8. Since it is known that associated sexually transmitted diseases act as co-factors or risk factors for AIDS and also for vertical transmission HIV seropositive mothers should also be investigated for these. If other STDs are present they should be treated and such women should be offered the opinion of therapeutic abortion or antiviral and PCP preventive chemotherapy because

of the added risks of rapid progression to AIDS, and of placentitis and vertical transmission to the offspring.

9. Universal precautions need to be followed stringently at the time of delivery of HIV seropositive mother. Caesarian section is recommended only for obstetric reasons. The use of double gloves, plastic aprons, and disposable materials is highly recommended as splashing of blood and amniotic fluid, contaminated with cervical and vaginal secretions, is common. Goggles are also recommended. The placenta should preferably be incinerated. Vacuum aspiration or foetal monitoring may be used judiciously since although the risk of peri-natal transmission may not be increased care must be taken to prevent infection of materials and instruments which may be capable of transmitting infection to health workers. Fumigation of the delivery room or operation theatre is usually not necessary but cleaning the floors and surfaces with 10% hypochlorite solution is essential before and after the delivery.

Research is going on to prevent peri-natal transmission of HIV. Borkowsky and krasinski have recommended the following strategies:

1. Decrease in the HIV load of the pregnant mother by the use of antiretroviral drugs.

2. Prevention of placental transmission by reducing chance of placentitis e.g. prevention or treatment of Syphilis, Chlamydia trachomatis (use of condoms, antibiotic therapy).

3. Increase in foetal resistance by producing maternal antiviral antibodies which cross the placenta and protect the foetus. This may be achieved by passive injection of high affinity human anti-HIV monoclonal antibodies to the mother and the new-born, or by active immunisation of the mother by an HIV vaccine. Passive immunisation of the new-born with immunoglobulins is known to protect it against hepatitis B virus and this needs to be evaluated for HIV.

## Conclusions

The management of HIV seropositive pregnant mothers is a complex problem involving a team approach by the obstetrician, the physician and the paediatrician. It is necessary to discuss the option of therapeutic abortion with the woman, and to inform her of the risk of aggravation of disease in herself, the risk of vertical transmission of HIV, and the potential adverse effects and benefits of antiviral treatment or other therapies on new-borns. Women who decides to continue pregnancy and those in advanced stage of pregnancy at the time of diagnosis should be closely monitored for CD4+counts and total lymphocyte counts. AZT and pentamidine or sulfamethoxazole/trimethoprim

prophylaxis should be considered for women with a decline in CD4+ counts below 500/ml.

The risk of post-natal transmission is reduced by avoidance of breast-feeding. In developing countries the risks of infections from top-feeding may exceed the risk of transmission of HIV from breast-feeding hence lactation should be continued. Current research and ongoing clinical studies are directed towards reducing the risk of vertical transmission and prevention of active disease in seropositive mothers and their infants.



## 50. HIV INFECTION AND CHILD HEALTH

*Prema Ramachandran\**

The second half of the 20th century witnessed tremendous improvement in child health. Improved diagnostic tests, anesthetic and operative techniques, availability of banked blood, antibiotics and other drugs provided and unparalleled opportunity to successfully tackle health problems in children. Efforts to reach services to the needy through primary health care approach were making a headway and impressive improvement in immunisation and ORT coverage had been achieved.

Health policy makers, professionals and public assumed that progressive global improvement in child survival and child health status is inevitable and will be achieved if not by 2000 AD at least a couple of decades later. The advent of HIV infection has however shattered this hope and it is now clear that redoubled efforts are needed even to prevent further deterioration in mortality rates.

### MAGNITUDE OF THE PROBLEM-GLOBAL

During the eighties almost all the available global epidemiological data were obtained on the basis of reported AIDS cases. These data compiled and reported by the WHO's global programme on AIDS and various national agencies formed the basis of current global and national AIDS control programmes. It is now well recognised that there is gross under reporting and under diagnosis in AIDS especially in developing countries. WHO estimate that the true global cumulative AIDS cases in adults might have crossed the 1 million mark and at least 500,000 cases of paediatric AIDS have occurred world wide (IN MID 1991).

It is now realised that using the data on AIDS cases as a basis for computing current infection load and drawing up future intervention programmes is not desirable. The first and the most obvious reason for this is, the well known variation in accuracy of diagnosis of AIDS cases and the completeness with which diagnosed cases are reported. The more important reason is that today's AIDS patient load represents the infection that occurred a decade earlier and does not give any information on the prevalence of infection at the time of the survey. Serosurveillance among asymptomatic individuals from high and low risk groups is the only method of obtaining reliable estimates of current infection load. Based on these data and the natural history of the disease, estimates on AIDS cases requiring care had been computed.

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Using all the data available from different sources, WHO estimates that currently (i.e. Mid 1991) there are 8-10 million HIV infected persons in the world. Of these, more than 3 million are woman; and 1 million are children. Over 2/3 of all the infected persons live in developing countries and have very little access to health care. In USA and Europe the HIV epidemic curve appears to be plateauing. However in Africa and Asia the steep rise continues. WHO estimates that 2 million HIV infected persons live in America; 0.5 million in western Europe; 6 million in Sub-Saharan Africa and 1 million in Asia. Unless very effective intervention programmes are implemented, the number of HIV infected persons in Asia is expected to cross those in Africa by mid 90s and by 2000AD, Asia might have largest number of HIV infected persons in the world. WHO estimates that by 2000 AD about 40 million men, women and children are likely to be infected by HIV; cumulative number of AIDS cases will be around 10 million. Heterosexual and parenteral transmission will be the most common modes of transmission of HIV infection and over 75% of the infected persons will be living in developing countries. Providing health care for these is likely to further strain the already severely strained resources of these countries. By 1989, an estimated 1.5 million uninfected infants were born to HIV infected women. Most of them are likely to lose one or both their parents as a result of AIDS and become orphans. This figure is also likely to double by the year 1992. Providing appropriate support to these homeless waifs until they become adults is a task that is likely to tax the welfare departments to the utmost.

## **IMPACT OF AIDS ON MORTALITY RATES**

In Pattern I countries, despite the current low prevalence of HIV infection, AIDS has become an important cause of death in women and children. In USA, AIDS is ranked as 8th leading cause of death in women of child bearing age and 10th leading cause of death in children between 1-4years. Because of lack of reliable cause and age specific mortality rates, it is difficult to compute similar figures in developing countries.

Prior to the advent of AIDS, UN had projected that the under 5 mortality rate would decline from 164/1000 live births in 1988 to 130/1000 by 2000 AD. Current estimates indicate that under 5 mortality was 166/1000 in 1988 and is likely to rise to 185/1000 by 2000 AD. A similar trend is likely to be seen in maternal and adult mortality rates. HIV has thus wiped out the decline in mortality rate achieved by 3 decades of toil. AIDS will result in death of men and women in reproductive age. As a result, children and elderly will be left without support. Women and children will become doubly vulnerable, both as AIDS casualties and AIDS affected survivors.



## HIV INFECTION IN WOMEN AND CHILDREN

Global efforts to obtain epidemiological data have shown that:

- a) Women form 1/3 rd the estimated 8-10 million HIV-infected persons.
- b) 26-50% of infants born to these women are infected;
- c) Nearly 50% of infected infants die by 2nd year;
- d) AIDS epidemic will result in steep rise in maternal and under five mortality rates.

Seropositive pregnant women (detected by screening during pregnancy) and pregnancy in known seropositive women have been reported by the ICMR serosurveillance centres from 1986-87. From these data it is estimated that between 1/3rd to 1/2 of the HIV seropositive persons in India are women. Most of them had been infected by heterosexual transmission; many do not belong to high risk groups. Majority are in the asymptomatic phase and may be unaware of the consequences of being HIV-infected. It has been variously estimated that between 100,000 and 400,000 women in India are infected by HIV.

Perinatal infection occurs in 20-50% of infants born to seropositive women. It is estimated that perinatal transmission accounts for 1-10% of all infections in different regions. The contribution of this mode of infection is likely to increase over the next decade when HIV infection becomes more prevalent in Asia.

It is estimated that average duration of asymptomatic period in HIV infected adults may be 8-10 years; once symptoms develop, progression of disease especially in developing countries is rapid; majority of AIDS case die within two years after diagnosis of AIDS. Progression of HIV infection in infancy and childhood is rapid; 50% of the infected infants die by two years of age and over 90% die by 5 years of age.

Illness and eventual demise of the mother from HIV infection has a catastrophic impact on the well being of the entire family. The infected infants may succumb more rapidly in the absence of maternal care while the uninfected infants face the grim future of becoming orphans early in childhood, with all its attendant adverse consequences.

## PAEDIATRIC HIV INFECTION

In India, Paediatric HIV infection is likely to be predominantly due to perinatal infection. HIV infection in children receiving unscreened blood/blood products had also been reported. So far one case of probable transmission of HIV infection through breast milk has been reported in India. Attempts are



underway to assess the load of paediatric HIV infection in the country and to document natural history of paediatric HIV infection in the country.

All infants born to seropositive women are seropositive at birth. HIV antibodies disappear over the next 6-18 months in uninfected children. There is no simple and specific test for diagnosis of HIV infection at birth. Diagnosis of paediatric infection is therefore difficult and is made on the basis of clinical presentation and results of tests for viral detection/isolation.

Studies from Europe and Africa have shown that about 30-35% of infants born to seropositive women are perinatally infected and that prevalence of preterm births and intrauterine growth retardation is higher among seropositive women. In India, prevalence of low birth weight (30%) and preterm births (10-15%) are high. Studies have been initiated to document the impact, if any, of HIV infection, on birthweight of infants. Attempts are being made to follow up infants born to seropositive women to find out perinatal transmission risk in these asymptomatic women and to document the course of paediatric HIV infection in India.

Because of the limitations of the HIV screening programmes in women, majority of HIV infected infants in India will remain undetected during infancy. Monitoring for growth and careful investigation of infants showing growth retardation and repeated infections may result in early detection of some of the pediatric AIDS cases.

## **HIV INFECTION AND BREAST FEEDING**

HIV has been isolated from breast milk. Intense research efforts over the last four years have resulted in documentation of a few instances where the infant might have been infected through breast milk. Various issues arising out of breast feeding by HIV-infected women had been discussed earlier by Dr. R.R. Gagkhedkar (CARC CALLING 4(3): 13-16, 1991).

## **HIV INFECTION AND IMMUNIZATION**

Increasing prevalence and awareness of HIV infection in infancy has led to concern about efficacy and safety of immunization of HIV infected infants and children. Experience with live and inactivated vaccines in HIV infected children suggested that these immunisations are free from major short term side effects. Risks and known consequences of natural infection are likely to be graver than the risks associated with vaccination even with live attenuated vaccines.

Taking all these factors into consideration, the WHO has recommended that:

(a) all asymptomatic HIV infected children should receive all standard vaccines both live and inactivated; (b) those with symptoms of ACR/AIDS should receive all other vaccines except BCG.

In view of the WHO recommendation that all asymptomatic HIV infected infants could receive all standard vaccines, the existing immunisation programmes in the country should be vigorously pursued.

## HIV INFECTION AND MCH SERVICES

Advent of HIV in the community should be yet another stimulus to the efforts to provide optimal MCH care. Providing appropriate contraceptive care to all eligible women would substantially reduce the birth of infected infants. It is essential that all aseptic precautions are meticulously adhered to during provision of antenatal, intrapartum and contraceptive care, so that accidental HIV infection is prevented. Breast feeding which is the best form of infant feeding should be encouraged as the method of ensuring infant survival and for growth and birth spacing. Irrespective of the HIV infection status, all apparently healthy infants should continue to receive immunisation against the six major vaccine-preventable diseases. With the introduction of mandatory screening of blood/blood products the risk of HIV infection in children due to the risk of parenteral transmission is likely to be minimised. *The advent of HIV infection and presence of undetected HIV infected pregnant women and infants in the community, thus only serve to emphasize the need to provide optimum MCH care to all and does not in any way call for major modification in the existing guidelines for provision of MCH services.*

## G.I. MANIFESTATION OF HIV INFECTION

HIV genetic material has been found in enterocytes and colonocytes. It is not known whether primary infection of these cells which do not express CD4 molecule can occur. Alteration in enterocytes, lamina propria, cellular elements, vasculature and intrinsic autonomic nerves of GI tract have been demonstrated in HIV infected individuals without any secondary infection. The functional significance of these changes are still not understood.

Majority of paediatric AIDS patients sooner or later have gastrointestinal problem with diarrhoeas and malabsorption leading to severe undernutrition as the major presenting complaints. The lesions in the gastrointestinal tract contribute significantly to the undernutrition in AIDS cases.



HIV infected children are highly susceptible to a wide variety of pathogenic and opportunistic infections of G.T. tract. In pattern II countries common bacterial infections (E.coli, shigella, salmonella, campylobactor) are often associated with severe bacteremia and high mortality rates in AIDS cases. Mycobacterial infection with *M. Tuberculosis* in tropical and *M. avium* intracellulare in temperate zones have been reported. Candidiasis is the most common fungal infection. Parasitic infections include amoebiasis-especially invasive one, giardiasis and cryptosporidiosis. Viral infections (Herpes, CMV and adenoviral infections) of GI tract have been reported mainly from Pattern I countries.

In paediatric HIV infection reported prevalence of neoplasia including kaposi's sarcoma and B cell lymphoma is low. Apart from bloody diarrhoea and weight loss, these children may report for emergencies - bleeding, obstruction and perforation.

## **IMPACT OF UNDERNUTRITION ON SURVIVAL**

Impact of undernutrition on survival in AIDS cases has been investigated in U.S.A. using total body potassium as an indicator of body cell mass depletion. These studies indicate that there is a progressive depletion of body cell mass as the patient neared death. The degree of wasting at death was independent of the cause-infection, malignancy or other factors in AIDS patients, suggesting that death from AIDS is related to the magnitude of tissue depletion.

Some of the preliminary data suggest that body cell mass repletion is possible by parenteral nutrition in patients in whom malabsorption was the major problem. Results are not satisfactory in patients with systemic infection. Nutritional status of AIDS patients appears to be one of the important determinants of incidence of opportunistic infections and evolution of disease. Treatment of infection and nutritional support can arrest or reverse weight loss and prolong survival in AIDS cases.

## **NUTRITIONAL SUPPORT IN HIV INFECTION.**

Nutritional support is needed in HIV infection for: a) maintaining optimum nutrition during the asymptomatic period, b) preventing further deterioration in nutritional status during acute episodes of infection in AIDS patients, and c) improving nutritional status during the 'stable' symptom-free period in AIDS.



Most of the efforts towards nutritional support to HIV infected persons are from developed countries, because (i) screening facilities are readily available and affordable so that seropositive children could be detected, (ii) peronal/national resources to take care of seropositive children and AIDS cases are available.

In developing countries where AIDS has added to the already existing burden of undernutrition among children, very few initiatives in this regard have been taken up. Even when AIDS is diagnosed, the treating physician face the dilemma whether the available scant resources be spent for nutritional rehabilitation of an undernourished but HIV uninfected child, or towards nutritional support of a paediatric AIDS child who is bound to succumb to the disease within the next year.

It is relatively easy to achieve and maintain optimum nutritional status in asymptomatic seropositive children. This goal can be achieved by minimal inputs into health care, and health education both in developed and developing countries. It is possible that good nutrition and freedom from common infections may prolong the asymptomatic period.

Once clinical symptoms appear it is very difficult to maintain optimal nutrition. Ample data exist to indicate undernutrition increases susceptibility to infections and lead to deterioration in nutritional status. If left unchecked this vicious cycle ends in death. Therefore, every effort should be made to prevent further deterioration in nutritional status in AIDS cases. Preferably this should be achieved by adequate intake of well balanced diet to meet the increasing nutrient requirements due to infections. Vitamin, mineral supplements in appropriate doses to meet the increased requirement may be given. Mega doses of these should not be given because they may further impair the immune status and other biological functions. Parenteral nutritional support may provide a dramatic if temporary respite in cases with severe impairment of absorption as in cases with extensive Kaposi's Sarcoma of gut. Apart from the cost involved providing the appropriate mix of nutrient, and using careful biochemical monitoring for providing adequate quantities of nutrients daily, there are numerous health problems associated with total parenteral nutrition. Hence, it should be resorted for a short period and only if there are clear indications.

## **PAEDIATRIC AIDS**

Paediatric AIDS is characterised by failure to thrive, poor weight gain/ actual weight loss, hepatosplenomegly, chronic fever, recurrent viral, bacterial or fungal infection of skin, gastrointestinal and respiratory tracts. Infection like tuberculosis, amoebiasis, giardiasis have been reported to be common in

pediatric AIDS cases in Africa. In Western Europe and USA, infections due to *Pneumocystis carinii*, herpes, cytomegalovirus, cryptococcus have been predominant. Available data from AIDS cases in India suggest that pattern of infection in India might be similar to the African one raising the hope for temporary remission of symptoms following therapy with effective and safe chemotherapeutic agents against these common infections.

Central nervous system abnormalities occur in 50-80% of infected children. Development delay, arrest and progressive deterioration add to the already existing distressing problems.

In Pattern I countries, failure to thrive and repeated infection in childhood are uncommon. Most of these infants and children were born to mothers belonging to high risk group; substantial proportions were born to known seropositive mothers and had been followed up from infancy. The number of infant/children with paediatric AIDS in these countries is small; 50% die within first 2 years and over 90% by 5 years of age. Because of these reasons, diagnosis of paediatric AIDS is not difficult; effort to provide optimal care to these children during the short period of (2-3 years) between diagnosis and death had not posed major problems.

In Pattern II and III countries failure to thrive is a common problem. Repeated episodes of gastrointestinal and respiratory infections are common, especially among urban and rural poor.

Studies from sub-Saharan Africa have shown that 10-30% of children with kwashiorkor and marasmus are seropositive. There are no differences in the history, type of infection or clinical presentation between seropositive and seronegative children with kwashiorkor. Available data from Pattern II countries and India indicate that majority of these children are born to mothers who do not belong to clearly recognised high risk groups. Only a very small fraction of the population have undergone HIV testing. Because of these factors diagnosis of paediatric AIDS in India and other Pattern III countries is difficult. It is possible that many cases were missed in the past few years. With increasing awareness about AIDS, there may be a tendency for over-diagnosis. Growth monitoring during the first five years and careful history, examination and HIV testing among those who show persistent growth faltering and repeated infections appear to be the most feasible methods for detecting paediatric AIDS in India.

The physicians face the problem, whether given the resource constraints, they should initially screen all severely malnourished children for HIV infection and admit only seronegative infants for intensive therapy. If after admission, a child was found seropositive common sense dictates that the child

should be sent back home to be with the parents because even with all the intensive care, he/she is unlikely to survive for more than few months. Given the scarce resources, physicians may prefer to spend the available money in providing care of acute life-threatening problems and infections in AIDS cases rather than improving nutritional status. Provision of nutritional care should obviously be a part of the over-all care for paediatric AIDS cases. However, such programmes should clearly take into account the existing realities in terms of number of persons affected and resource both personal and national that will be available.

## CONCLUSION

India has the advantage that HIV infection reached the country in early or 'mid' - eighties by which time a lot of information on HIV became available. ICMR took full advantage of this and the availability of HIV antibody test kits and defined the epidemiology of HIV infection in India through serosurveillance very early in the course of HIV epidemic. Data from these studies provided some insight into the magnitude of the problem and showed that women and children were specially vulnerable both as AIDS casualties and as AIDS survivors. National AIDS control programmes has been drawn up on the basis of the these data and is being implemented through the Central and State Health services infrastructure with minimum essential additional inputs. Thus the country has the opportunity of containing and controlling HIV epidemic at an early stage and limit the ravages of HIV infection in children.

*SOURCE CARC CALLING .VOL4 . NO4. OCT-DEC 1991.*



# 51. AIDS RELATED KNOWLEDGE AND ATTITUDE OF MEDICAL STUDENTS AND IN SERVICE DOCTORS

*Dr. M.K. Vasundhra\**

## Introduction

A trained health manpower is expected to form the back bone of health services. The health personnel are expected to address themselves to the critical issue of creating community awareness and for counselling for HIV infection. It is, therefore, essential to gain an insight into the knowledge and attitude of health professionals to elicit the needs for their training programmes.

## Methodology

Pre-tested self administered questionnaire consisting of 40 questions with multiple choice items was used to elicit the knowledge and attitude of 232 respondents including 175 Final Year MBBS students and 57 in service doctors who were deputed for ICDS training.

## Observations.

1. Cause: More (40.36%) in-service doctors than (26.29%) medical students were ignorant about the Human Immunodeficiency virus being the cause of AIDS. This difference between two categories of respondents was significant (total: 1.99,  $p < 0.05$ )
2. Pathogenesis: 82.85% medical students and 38.59% in service doctors were aware of the fact that the T4 Cells were predominantly affected.
3. Spread of HIV infection: The sexual, blood borne and perinatal transmission of HIV infection were known to 96%, 94.28% and 90.85% medical students. The knowledge of the doctors regarding above modes of transmission was 98.24%, 89.47% and 78.96%.
4. Misconception regarding spread of HIV infection:
  - 4.1. Casual Contact: More in service doctors (24.56%) than (6.85%) medical students thought that the infection could spread through casual contact. The difference in knowledge of medical students and in-service doctors was statistically highly significant.

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- 4.2. Air-borne: 12.50% respondents including 13.14% medical students and 10.52% in-service doctors thought that coughing could help spread the infection; believing it to be airborne.
- 4.3. Vector-borne: 20.25% respondents including 26.31% doctors and 18.28% students thought that HIV transmission was possible through mosquito bite.
- 4.4. Haircutting: (Barber's shop) was feared as a mode of transmission of HIV infection by more (23.42%) medical students than (10.52%) in-service doctors. The difference observed between two group of health care workers was significant (total: 2.097,  $p < 0.05$ ).
- 4.5. Urine as a source of HIV infection: was expressed by more (33%) medical students than (15.78%) doctors (total: 5.48,  $p < 0.001$ ).
- 4.6. Risk perception: 54.38% doctors and 50.85% medical students feared that they were at a high risk of contracting HIV infection during their routine professional work.
5. Incubation period: 68.10% respondents including 71.42% medical students and 57.8% doctors knew about the long incubation period of AIDS.
6. Infectivity: 77.15% respondents knew that the infection was lifelong. More (85.63%) doctors.
7. Screening tests: Only 46.12% respondents knew about the ELISA and Western blot tests for screening for HIV infection. The ignorance was more marked among 77.06% doctors than among 41.29% medical students.
8. High risk groups: Identified were STD cases; homosexuals; paid blood donors by 94.82%, 93.53% and 86.63% respondents respectively.
9. Manifestations: of HIV infection were known to 82.32% respondents, majority of whom, (88.57%) were medical students.
10. World AIDS Day on 1st December of the year was known to only 35.77% respondents. Ignorance was more marked amongst (85.97%) doctors compared to that among (57.15%) medical students.
11. Preventive measures:
  - 11.1. Safe sex: Monogamy, use of condoms and avoidance of sex with strangers was known to 74.56% respondents. There was no comparable difference in knowledge of medical students and doctors.
  - 11.2. Use of single sterilised syringe with multiple sterilised needles: was thought to be a safe procedure by 67.24% respondents. More doctors

(80.70%) than (62.85%) medical students thought this to be a safe procedure.

- 11.3. Disinfection procedures: The knowledge regarding the disinfection procedures was extremely poor amongst both medical students and the in service doctors. The difference in knowledge persons was statistically significant being higher amongst medical students than amongst in service doctors.

Only 15 (9.55%) medical students and 1 (1.75%) in-service doctors knew about use of 3% Hydrogen peroxide as disinfectant against HIV infection.

10% Household bleach: as an available disinfectant was known to only 20 (11.42%) medical students and 1 (1.75%) doctors.

14 (8%) medical students and 4 (7.01%) doctors knew about the disinfecting quality of 70% ethanol.

## 12. Management:

- 12.1: Isolation: 48% medical students and 50.87% doctors suggested isolation of HIV infected persons.
- 12.2. Denial of First Aid: More doctors (35%) than (14.85%) medical students expressed that the HIV infected persons should be denied first aid. The difference in attitude between the two categories of health professions was statistically significant (total: 2.6%  $p < 0.05$ ).
- 12.3. Counselling: 36.57% medical students and 42.10% doctors know that counselling was an essential component of management of HIV infection.

## Summary and Conclusions

The study of 232 respondents including 175 medical students and 57 in service doctors revealed that misconceptions existed amongst them regarding the spread of HIV infection. Casual contact; mosquito-bite; coughing and hair cutting were believed to be the modes of spread of HIV infection by 11.20%, 20.25%, 12.50% and 23.27% respondents respectively. This is a matter of grave concern. This is also an urgent need to forge a positive attitude amongst medical personnel as 40.70% respondents suggested isolation while 19.82% respondents suggested denial of first aid to the HIV infected persons. Glaring gaps in their knowledge regarding disinfection procedures were identified. Only 1.75% doctors knew that 3% hydrogen peroxide and 10% household bleach could be used as disinfectants. 8.70% doctors felt that a single sterilised syringe could



be used for multiple injections provided the sterilised needles were changed for each prick. An urgent need to train the health personnel is indicated to prepare them to meet the impending challenge.

*Souce: CARC CALLING. Vol.6 No.1 JAN-MAR 1993.*

## 52. STATE AIDS PROJECT CELL, TAMIL NADU

### HIV POSITIVE DETAILS 1986-1993 (October)

Details	Tamil Nadu	India
Total Number of samples screened	5,62,501	19,33,830
Number of persons sero-positive	4,520	13,448
Sero - positivity (per thousand)	8.0	6.95

Sl. No.	CATEGORY	HIV POSITIVE IN			
		Tamil Nadu	%	India	%
1.	Hetrosexuals	2115	52.74	5,651	42.04
2.	Homosexuals	8	0.20	41	0.30
3.	Blood Donors	852	21.25	2,202	16.37
4.	IV drug users	22	0.55	1815	13.50
5.	Antenatal mothers	36	0.90	65	0.48
6.	Relatives of HIV patients	79	1.37	122	0.91
7.	Suspected ARC\AIDS	308	7.68	613	4.56
8.	Others	590	14.71	2,528	18.90

# ESTIMATES OF THE NUMBER OF HIV INFECTIONS IN URBAN INDIA BASED ON SEROSURVEY DATA 1991

Group	Estimated Size (millions)	Prevalence Rate(%)	Estimated No.of HIV (+)
Female Prostitutes	1	15	150000
Clients of Prostitutes Female	3	7.5	225000
Injecting drug users	0.05	50	25000
Male homosexuals	0.15	20	30000
SA/females	43	0.07	30000
SA/males (15-45)	52	0.34	177000
Rural SA Population	263	?	?
TOTAL			>637000

Rural SA population (15-45)

SA = Sexually active



## HIV PERIOD PREVALENCE RATES IN SELECTED POPULATION OF INDIA

Group/prevalence	1991	1992
Multipartner sex males (STD attendants, history)		
-tested	3.900	5.485
-positive	22	89
- rate/1000	5.6	16.2
Blood donors:*		
- tested	19,160	15,297
- positive	7	13
- rate/1000	0.37	0.85
Pregnant women:**		
- tested	2.344	6.031
- positive	2	7
- rate/1000	0.62	1.16

\* Actual periods compared are 1990 through May 1991 and June 1991 through March 1992

\*\* Actual periods compared are 1990 through October 1991 and November 1991 through May 1992.

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# 53. ASIAN PERSPECTIVES ON HEALTH AND QUALITY OF LIFE

By

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## INTRODUCTION

Among the asian countries, China, Thailand, Indonesia, Sri Lanka, South Korea, Malaysia, and Taiwan have made significant advancement in promotion of health and improvement in quality of life of their population. No doubt Singapore and Hongkong are equally important in this context, but they are very small countries for the comparison purpose. The experiences of some of these countries will be more valuable for promoting health programmes in other sister Asian countries like India. The non-availability of comparable data on several parameters is a hindrance for comparative studies. Therefore, a comparative perspective on health from a selected few (7) Asian countries has been attempted. They are: China, Indonesia, Thailand, Sri Lanka, South Korea, Bangladesh and India. A glance through this paper, reveal will that India and Bangladesh are lagging behind in most of the health profiles. Comparison of health perspectives in these seven countries of Asia gives meaningful and representative information on Asia, in general.

In this section, the discussion is focussed on available data on various dimensions of health among these countries, which include: GNP spent on health, medical care as percentage of total household consumption, access to safe drinking water, doctor-population ratio, access to health services, access to sanitation, coverage of immunisation, care of pregnant women and children by trained personnel, low birth weight, daily calorie intake per capita, infant and childhood mortality, maternal mortality, longevity, communication technology, adult female literacy rate as percentage of male literacy and contraceptive prevalence. All these aspects together will provide the profile of health and quality of life of population in developed and less developed Asian countries.

This paper aims at studying a selected few parameters of health profiles of selected Asian countries. the objectives given below will help to understand

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the details presented in this unit: (1) to know the policies and programme aspects related to health promotion in selected Asian countries; (2) To compare the health status, and mortality levels among seven major Asian countries, (3) To examine the nature of inputs and health promotion programme; and (4) To assess the level of quality of life in terms of (a) communication technology; (b) education of women; (c) Calorie intake; (d) contraceptive prevalence rate; and (e) life expectancy.

## **HEALTH POLICY IN ASIAN COUNTRIES**

These seven Asian countries more or less had their politically independent existence during early 1950s. Further, they also promoted the National Health promotion in parallel programmes during the same decade. However, these countries follow differential health policies particularly in terms of investment made in the health sector, which may be a major determining factor of their differential success in this sector of social development. Among these countries for which information is available, Sri Lanka and Thailand spent 1.0 to 2.0 per cent of their GNP, for health programme as against less than one per cent among the remaining five Asian countries. At the micro-level investment made on medical care in the families of these countries, also showed considerable variation. In this context, Thailand and south Korea topped the list with 5 per cent of their family income earmarked for health programmes. It is surprising to see that India ranked third by spending only three per cent of the family income for health promotion programme. In contrast, two per cent each is spent in rest of the Asian countries except China. In China, most of the health facilities are freely given by the Government and China leads in this respect. In spite of free medical care provided by the Government, the Chinese spent one per cent of their family income too. Thus, in the National Health Policies of these Asian countries different investment and emphasis have been given by the Government and by the people. As it can be seen, China made a breakthrough in improving the quality of life of her population through her effective health schemes and policies. It is due to the fact that China had given high priority to health promotion programmes in their overall developmental programmes as compared to other Asian countries.

## **HEALTH INFRASTRUCTURE AND INPUTS**

Health infrastructure consists of several parameters which have direct as well as indirect influence on health status of the people. These factors include aspects like health personnel viz., doctor-population ratio, nurse-population ratio, peripheral worker-population ratio, bed-population ratio, distance to



hospital, transport facilities, availability of specialists, super specialities, hospital facility and so on. Out of these parameters certain high priority factors are discussed below.

**Health Delivery Personnel:**

(a) *Doctors:* In most of the Asian countries more or less similar hierarchy of staff, types of hospitals and human resources development programmes are observed. However, facility for human resource development in the field of health care are more available in China and India but very inadequate in the rest of the Asian countries under study. Therefore, these small Asian countries depute their candidates to India, England and other developed countries for training in the field of medicine. Of course, they have facility for training peripheral workers in the field of health. Despite these deficiencies noticed in human resource development in most of the small Asian countries, they do not lag behind the big countries like India and China in health delivery system.

**Table 1: Doctor and Nurse Population Ratio**

Countries	Population Per	
	Doctor	Nurse
China	1,000	1,710
India	2,520	1,700
Indonesia	9,460	1,260
Thailand	6,290	710
South Korea	1,160	580
Bangladesh	6,730	8,980
Sri Lanka	5,520	1,290

As it can be construed from the table-1, China and South Korea have comparatively the best advantage of having one doctor per 1,000 and 1,160 population each. In other words, number of doctors in India is not even half of what it is in China as well as South Korea. It is one of the most critical infrastructural facility for better health delivery system in any country. Therefore, inadequate number of doctors to serve the rural population is the key factor for the general poor health delivery system in most of the Asian countries. Although, India ranks in this context next to China and South Korea, there is distortion in the distribution of doctors in our country because more than two-

thirds of the doctors concentrate only in urban areas to serve one-fifth of India's total population.

(b) *Nurses*: As regards the availability of nurse-population in Asian countries, South Korea tops all other six Asian countries having one nurse for every 580 population as against the maximum of 8,980 in Bangladesh. India and China have moderate nurse-population ration (1: 1700). Interestingly small Asian countries like Indonesia (1:1260) and Sri Lanka (1:1290) have much favourable nurse-population ratio but not doctor -population ratio. But the service rendered in the field of health delivery system is anything but satisfactory. Should we not identify the factors for this problem and provide apt and timely remedy on war footing?

(c) *Peripheral Workers*: Our reach of the programme at the peripheral level depends very much on the number and nature of peripheral functionaries employed in a country. Such service is well organised in China through the bare-foot doctors and so also in South Korea but not in other Asian countries under study. Although India, has a large number of indigenous Dais and so also Dukuns in Indonesia, they have not been properly trained, modernised and effectively organised and used in these countries. No doubt, Dai can not be equated with bare-foot doctor because the latter is a qualified person while the former is a quack. In addition, there is no systematic involvement of these personnel in health programmes. Further, India produces largest number of qualified nurses in Asia and so also doctors but very large number of them leave India to serve in other countries- brain drain. Such an unfortunate situation does not exist in most of the Asian countries. There fore, should we not have a re-thinking on human resource development in the field of health, man-power planning and successful utilisation of the well trained man-power equitably on a need - based - basis in rural and urban areas as it has been done successful in China?

Utilisation of the existing health facilities by the people concerned is another problem as noticed in the Asian countries. It varies from country to country. However, in most of the Asian countries, except China and South Korea 50 per cent or more of the health facilities are not being used. It amounts to a colossal waste of resources, investment and wastage of inputs in the field of health. For instance, when three-fourths of the health facilities in China have been used by the people, hardly one-third of the facilities are being utilised in India. No doubt, it tremendously varies in India. Coming to the states in India, it is being used by over 80 per cent of the population in Kerala, whereas in Uttar Pradesh the same facility is not being made use of even by one-fourth of the population. In addition, excess health facilities exist in urban areas while very

inadequate facilities exist in rural areas. Should we not do something urgently in this direction.

Distortion in health inputs exists glaringly in certain Asian countries particularly in India. While China gives the highest priority to rural peripheral health delivery system, In India maximum input is provided to urban hospitals and creation super of speciality hospitals again in urban areas. In fact most of the patients may not need super speciality care. Therefore, it may be questioned how far is it justifiable in investing more money for a minority of population living in urban areas at the cost of majority of the rural population? In the two biggest countries of Asia namely China and India health delivery is well taken care of especially in southern part of China as in India but strangely not so in the northern regions of these countries. In addition, certain regions of ethnic minorities in China and of tribals in India are not served properly with sufficient health care programmes. Such distortions are common in other Asian countries as well.

**HEALTH INPUTS:** Inputs of the health programmes also include immunisation-Oral dehydration therapy (ORT) access to health services and communication technology. all these inputs substantially vary across these Asian countries. The table - 2 gives an overview of these inputs provided through health delivery system in the Asian countries.



**Table 2: Different service inputs- Immunisation, ORT use rate and access to health Services**

COUNTRIES	Percentage fully immunised 1 Year old children (1990-91)				Pregnant women - Tetanus	ORT use rate (1987-91)	% with Popula- tion health care Services access to (1988-90)
	BCG	DPT	Polio	Measles			
China	96	95	96	95	-	54	90
India	92	89	89	86	80	14	-
Indonesia	87	83	82	78	52	45	80
Thailand	99	90	91	79	76	43	70
South Korea	76	80	79	96	-	-	45
Bangladesh	86	60	60	53	78	26	40
Sri Lanka	85	83	83	76	50	76	93

A comparison of various inputs of health promotion programmes in the seven Asian countries gives a general picture of the preventive and curative facilities in these respective countries. Regarding preventive care viz., immunization programmes, prevention of TB programme (BCG) have become almost universal in most of these countries. Similarly, DPT, polio and measles vaccinations have spread extensively in most of the countries, except Bangladesh. In all these preventive measures although India has progressed more or less on par with most of the progressive Asian countries, except China where the success rate is almost cent per cent on most of these programmes the outreach and quality of services in India are very much lagging behind.

Moreover, provision of tetanus toxoid to pregnant women to prevent risk in life of mother and child and promotion of ORT to avoid dehydration deaths of children resulting out of diarrhoea are yet to become universal in many countries; in fact their coverage range is between 25-80 per cent only in several countries. Further, overall accessibility to health care service in general also falls short of the real requirements in Bangladesh, South Korea and India. On the contrary, China, Sri Lanka, Indonesia and Thailand who have succeeded extensively in promoting these programmes, have achieved greater success in health care. However, India, Bangladesh, South Korea and such other countries in Asia have to go a long way to achieve complete coverage in health programmes especially prevention of communicable diseases.

## **SANITATION AND WATER SUPPLY**

Sanitation and water supply are two sides of the coin that effect the health status in rural and urban areas equally. Their status and availability deteriorate as a result of population pressure (density). Moreover, they also reflect clearly the level of development of a country. The level of sanitation and availability of water supply are very unsatisfactory in most of the developing countries but not so much in the developed countries. Indeed, rapid urbanisation and industrialisation being the main causes have adversely affected the sanitation in most of the mega cities even in the developed countries. . As a result of education and modernisation, Sanitation improved considerably in the developed countries but it remained very low in developing countries because of the low social development of their population and its unawareness. Similarly, water supply (potable water) is becoming a scarce commodity as a result of rapid and unplanned growth in population and ecological changes. With population growing rapidly and ecology badly disturbed by denuding rain forests, safe drinking water has become scarce. According to UNESCO, in the 1850 past per capita availability of fresh water was 33,000 cubic meters per

person million per year but it has reduced to very meagre level of 8500 cubic meters per person (UNESCO, 1990:43). This is true in most of the Asian countries, for instance, drying up of cauveri river in southern part of India is a standing example of ecological degradation which affects the sanitation condition in Karnataka and Tamil Nadu states.

**TABLE 3: Percentage of population with access to safe drinking water and sanitation.**

COUNTRIES	% of population with access to	
	safe water (1988-89)	sanitation (1986-87)
China	74	96.4
India	46	12.6
Indonesia	60	43.6
Thailand	74	62.4
South Korea	75	100.00
Bangladesh	N.A	N.A
Sri Lanka	60	46.9

N.A - Not available

By a look at the table-3 and a comparison of scenario of availability of safe drinking water, one can notice significant differences among the seven Asian countries. Countries like South Korea, China and Thailand are better in respect providing safe drinking water to 75 per cent of their population as against India which is able to serve half of its population i.e., 46 per cent with potable water. Even the other Asian countries, except Bangladesh, are also ahead of India in providing these basic necessities of life to their population. In other words, India and Bangladesh are the least developed countries when compared to other Asian countries under reference in providing safe water for drinking. It is well known that diarrhoea and dysentery, which are water-borne diseases, are the major killers of infants in developing countries. In addition, cholera epidemic is also caused through water and food contamination. Jaundice, typhoid, and the like are spread like-wise. The water-borne diseases are more common in Bangladesh and India than in the other Asian countries under study.

Naturally the level of sanitation reflects the development of a country. It also reflects the cultural diversity of the population because beyond develop-



ment, sanitation is also conditioned by the culture of the population. For instance, sanitation is of very high order in Kerala state in India, particularly among the kurichia tribe in Malabar region and also among certain other sects of Brahmins. Similar situation exists in many Asian countries like in Thailand, China and South Korea.

Sanitation promotes health status of the people. How to develop consciousness on health or awareness of sanitation should be the major concern today because bad sanitation adversely affects the health condition of the population leading to several endemic enteric diseases. Which can be controlled only through sanitation. A glance in to the existing sanitation in Asian countries throws much light on this.

Among the Asian countries, South Korea and China lead with universal better sanitation which is not found in all other Asian countries except Japan. Next to them, Thailand has progressed considerably in promotion of better environmental sanitation. India (13%) and Bangladesh are at the bottom level with very poor sanitation facilities compared to the most of the other Asian countries. Therefore, improvement of sanitation assumes a very high priority for the promotion of health in India.

## **STRATEGIES CUM HEALTH EDUCATION**

Strategy followed for health delivery system varies in different Asian countries. In this context, Chinese experience is unique. Two important strategies followed in China are worth emulating for the rest of the Asian countries including India (1) China has an array of successful bare-foot doctors who can reach most of the population throughout the country. These bare-foot doctors are diploma holders in medicine. In fact, they are selected from all walks of life and given 3 years integrated training in medicine covering indigenous Chinese system of medicine with allopathic system of medicine. The second novelty of Chinese health delivery system is called the family bed system. In China patients will be screened while visiting the hospitals and most of the patients will be sent back to their families after diagnosis and they are given service in their respective homes by the bare-foot doctors. Such service minimises the need for more number of hospitals and in addition psychologically give confidence to the patients which is a major pre-requisite for curing the disease because the patient is in the midst of the members of the family. These systems of service followed in china deserve replication and emulation in India too unhesitatingly.

The strategy of using different systems of medicine is found to vary in different Asian countries. In this context, once again China is in the forefront.

For instance, acupuncture is not only popular throughout China but is also being practiced in several developed countries. Similarly utilisation of indigenous herbs and bio-medicines, like Ginseng which is found to be effective for longevity, are very popular in China and Korea. In fact, Chinese diet itself is very appropriate for healthy living because they consume only a cup of rice during lunch and dinner and the rest is supplemented by fish, meat and vegetables. In South Korea and Indonesia also peripheral indigenous workers are very popular and useful for health delivery system. They also use indigenous system of medicine and service. For instance, the Dukuns of Indonesia are successful mid-wives in reducing the maternal and infant mortality. On the other hand, in India we have indigenous systems of medicine - Ayurveda, Siddha, Unani, Kaya Kalpa Chikitsa medicine along with allopathic and homeopathy systems. They are not suitably made use of in most states of India except in Kerala and Gujarat. In fact, several medicines of these systems are very efficacious for health promotion and they are cost effective as well. Therefore, should we neglect them and develop a sort of prejudice against these indigenous systems of medicine? What should be done to improve their utilisation in our country? When we improve the utilisation of these systems of medicine throughout India, we may also make a break through in controlling certain diseases and epidemics as in China and South Korea.

**Health Education:** 'Health Education can be defined as the art of applying social and health sciences to facilitate the development of healthy life styles and behaviour among people. Information, communication, motivation and media are essential and integral components of health education. It helps people become health conscious and develop and attach a high value for health. It involves multidisciplinary team work in planning educational strategies, in designing multi-media campaigns, in effective use of electronic and mass media and in folk communication activities. It is the art of working with people of various backgrounds to satisfy them of their needs by their own actions and resources and by mobilizing the resources of other sectors. Its main function is to create appropriate educational opportunities in varying environments for people to make their own enlightened decisions and act upon them. For this purpose, it uses home, market, and meeting place (community health education), school (school/student health education), work place (industrial health education), hospital (patient education), and employs methods and media suitable to the target groups and problems' (Ramakrishna, 1992:18).

Health promotion can be achieved largely through health education. It is cost-effective, trouble free and appropriate service for the promotion of health. However, it is differentially promoted in several Asian countries with varying success rates. Although health policies in most of the Asian countries provide



priority for health education in the document, at the implementation stage priority is shifted to curative services at the neglect of health education. It is largely due to the defective human resource development on the part of the proceeders. If health education is promoted seriously, morbidity and mortality can be effectively prevented. In fact, health education and its importance are not only increasing in the context of changing patterns of morbidity but also become necessary to avert the dreadful diseases like AIDS and cancer.

Cultural practices may be beneficial or harmful in a society. Health education should identify such beneficial practices for introducing appropriate education for healthy living. In this context, life style is the most important aspect of the culture, in fact, life style forms the major determinant of cancer, AIDS, Cardiovascular diseases and diabetes today. It is well known and beyond doubt that smoking and chewing of tobacco cause oral cancer. Sexual hygiene prevents the cervical cancer, likewise oral hygiene prevents mouth cancer and the intake of fibrous food checks the colon cancer. All these are culturally determined.

Similarly type of sexual practices, hygiene involved and the use of condoms determine the occurrence of AIDS. Value attached to chastity is well known in several Asian countries. Of course, its degree varies from community to community. Such value system is a positive cultural trait that prevents AIDS.

Another major disease like cardio-vascular problem is again caused largely by life style factors. For instance, excessive intake of fat, status syndrome associated with obesity, food habits, longing for more comforts and sedentary life are aspects of culture which promote cardiovascular diseases. On the other hand, value attached to vegetarian food particularly among certain communities in India and Indian origin population in Asian countries acts as a benevolent cultural factor to minimise cardiovascular diseases.

Similarly, diabetes and communicable diseases can also be affected by certain cultural practices either adversely or favourably. Therefore, understanding of culture in human behaviour forms a pre-requisite for the success of health education. Although certain cultural factors, particularly life style affect health in most of the Asian countries, very less effort has been made, so far, through health education to re-orient the life style for the benefit of health of people at large. In this context more literature dealing on such themes is to be created and disseminated through formal and non-formal health education using all the available media. It is one of the high priority efforts needed under health education.

Promotion of personal hygiene and environmental sanitation are essential components of health education. Out of the seven Asian countries detailed



here, Bangladesh and India are the most backward countries regarding personal hygiene and environmental sanitation. The level of hygiene and sanitation are of a higher order in China, Korea, Indonesia and Thailand. Even the situation is far better in Sri Lanka when compared with India and Bangladesh. The major reasons for such improvement of hygiene and sanitation in other Asian countries are partially conditioned by their cultural practices and promoted through education and modernisation. Therefore, high priority must be given to personal hygiene and sanitation to prevent several communicable diseases in India and Bangladesh whereas they have been very much controlled in China, Indonesia, South Korea and Thailand,

## QUALITY OF LIFE IN AISA

Giving better quality of life to the citizen is the aim of all facets of development and particularly of health promotion programme. Of course, diverse programmes of development give different emphasis to one or the other components of development schemes. Nevertheless, the goals of all programme work through different routes of development to the ultimate goal of improving the quality of life. In this context, certain aspects of social development, which have close linkage between them have to be examined closely to explore out their interactions and complimentary nature to assess the overall quality of life. The indicators that have more relevance to explain quality of life particularly oriented to the health and allied aspects have been discussed here. However, not all such factors are covered here because of the non -availability of certain data. Nevertheless, most of the major indicators of quality of life have been included here. They are nutrition, health and wellbeing of the individual, longevity, social and technological aspects.

Quality of life is a relative, multi-dimensional-cum- multi-disciplinary concept which aims to achieve alround improvement in human life. As a result of such progress in quality of life, human beings, may improve their life physically, mentally, socially and spiritually. It also leads people to attain better healthy life through safe ecology, relatively tension free and peaceful environment to pursue sustainable future development.

In a population of a given country, certain population will be extremely disadvantaged because not only the quality of life is poor but also the existence is at stake. The earnings are so low that they can not afford to have a minimum nutritionally adequate diet plus essential non-food requirements. Such population is termed as people below absolute poverty level. According to this concept, let us observe how these Asian countries have crossed this bottom level of quality of life. As expected most of the Bangladesh population lives below

poverty line (86%). India is second to Bangladesh with 33 per cent of population living below poverty line, which of course is significantly much less compared to the extreme poverty-stricken population of Bangladesh. However, one is surprised to see that 25 per cent of Thailand population still lives below poverty level though Thailand is far developed when compared to India. It is astonishing to see that South Korea (11%) tops the Asian countries (excluding Japan) followed by China (13%) and Indonesia (16%) in raising most of their population above poverty line. Among these three countries only negligible population continues to live below the poverty line. Is it not a lesson for India to learn rapidly to raise her one third population above poverty line and improve the quality of life?

Another indicator manifesting the quality of life is the daily per capita calorie intake as percentage of the requirement. Once again Bangladesh (103) followed by India (109) are the two poorest countries where per capita calorie intake is the least among other Asian countries. Surprisingly Indonesia (136) tops in calorie-intake followed by China (126), South Korea (120), Sri Lanka (119), and finally Thailand (115). Low birth weight of baby will also be a function of calorie intake along with other factors. In this aspect, China (9.0%) and South Korea (9%) have the least problem of low birth weight babies, which speaks about better quality of life of most of the children. More or less similar situation exists in Indonesia (14%) and Thailand (13%). Therefore, the disadvantaged countries as far as infant's quality of life is concerned, are Bangladesh (50%), India (33%) and Sri Lanka (25%). The above factors very much influence infant, childhood and maternal mortality. The level of these three mortality rates also indicates the quality of population among these countries. As far as the mortality rates are concerned, Bangladesh is on the top of the list with the highest level of mortality followed by India, Indonesia and Thailand respectively. However, South Korea followed by China have the least infant, childhood and maternal mortality rates. Even Sri Lanka is better privileged in this respect than India and Bangladesh. What lesson can India learn out of this? How Korea, China, Thailand and Sri Lanka were able to succeed in drastically reducing the mortality patterns? The answers to this question can be seen in the earlier sub-section like better sanitation, availability of safe drinking water, favourable ratios of doctor, nurse and paramedical personnel, effective strategies followed in health promotion, priority given to health programmes with emphasis laid on health education and measures for prevention of diseases.

Longevity is a crucial indicator of quality of life which is once again influenced by the above mentioned factors and two other factors that follow, namely female literacy and communication facilities for education. In this



respect china (72) followed by Sri Lanka (71) and South Korea (70) surpass the Asian countries (excluding Japan) in reaching the top level of life expectancy. Of course, Thailand (69) is equally successful in this regard. Once again Bangladesh (52) is unfortunate in this aspect because her life expectancy is the lowest among other Asian countries under study. However, India (60) and Indonesia (62) are far behind the four countries as referred to above already. It is unfortunate that India having the third largest trained scientific man power in the world is lagging behind very much in expectation of life at birth compared to several other Asian countries.

Two other social and technological indicators of equality of life can be measured on the basis of female literacy and the availability of communication technology (Radio and Tv). Female literacy has become universal in South Korea (95%), Thailand (94%) and Sri Lanka (90%). Equally fascinating is the successful achievement of female literacy in China (74%) and Indonesia (74). Here again, Bangladesh (47%) is the most backward nation followed by India (55%). It is the female illiteracy which is the key factor for poor quality of life because it has got linkages with most of the factors mentioned above. Yet another equally important manifestation of quality of life is the use of effective mass media viz., Tv and Radio. Regarding Radio, South Korea is the only country which has universal coverage. However, Sri Lanka, China, Thailand and Indonesia have progressed considerably in this field. But they are still backward because majority of the population do not own Radio. The situation in Bangladesh and India is still worse. They have to go a long way in improving this aspect of quality of life which is necessary for essential development of knowledge and improving the life style. Regarding TV, it is very negligible in most of the Asian countries except in South Korea and Thailand. but even there it is very inadequate. For developing countries, no doubt, TV is a luxury at present but not Radio. Quality of life of mothers and children and also family as a whole is also reflected based on the adoption of small family norm and acceptance of contraception. In this respect, South Korea

(CPR 77) and China (CPR 72) have achieved spectacular success followed by Thailand (CPR 66) and Sri Lanka (CPR 62) but Bangladesh (CPR 310, India (CPR 43) and Indonesia (CPR 48) have to go a long way to achieve success in this programme in order to improve the quality of life of women in particular. (See Table 4)



**TABLE: 4**  
**SELECTED DIMENSIONS OF QUALITY OF LIFE IN ASIAN COUNTRIES**

Country	% of Rural Pop. below absolute poverty level (1980-89)	Daily per- capita calorie in take as % of require- ments (1988-90)	% of in- fants with low birth weight (1990)	Child (un- der-5) mor- tality rate (1991)	Infant under-1) mortality rate (1991)	Maternal mortality rate (per lakh) (1980-90)	Life ex- pectancy at birth (e:) (1991)	Adult Female literacy rate as % of males	Contraceptive prevalence rate (%) (1980-94)	Communica- tion Techno- logy (No. of sets per 1000)	Radio T.V.
1	2	3	4	5	6	7	8	9	10	11	12
China	13	126	9	27	22	95	72	74	72	184	27
India	33	109	33	126	84	460	60	55	43	78	27
Indonesia	16	136	14	86	61	450	62	74	48	144	55
Thailand	25	115	13	33	28	71	69	94	-	182	109
South Korea	11	120	9	10	9	26	70	95	77	1003	207
Bangladesh	86	103	50	133	101	600	52	47	31	41	4
Sri Lanka	-	119	25	21	16	80	71	90	62	194	32

Epidemiological transition takes place in a country based on the level of overall development. When a country is economically and socially backward and so also manifest poor quality of life people, such countries suffer mostly from deficiency, want diseases, communicable and other diseases caused by poor hygiene, sanitation and so on. All these reflect the state of pre-transition in epidemiological change. On the other hand, when a country progresses, hygiene, sanitation and nutritional status will improve concomitantly. Concurrently pollution of water, soil air and of noise grows with the development. As a result, they lead to occurrence of different types of diseases like cardiovascular disease, cancer, diabetes and so on. But communicable diseases in the poor countries will be reduced to the minimum. These changes in disease patterns based on level of development of a country contribute to the epidemiological transition. In fact, all these changes affect the quality of life of population both in developing and developed countries.

## CONCLUSION

To sum up, all the countries under study have obtained freedom from colonial rule more or less in 1950's. In contrast, the progress of development is not the same in these countries. The differences start with investments made in health sector, Thailand and South Korea invest 5 per cent of GNP on health improvement. In China not only government but also individuals invest in health improvement. Further, the doctor-population ratio is better in China, South Korea and India. The nurse population is better in South Korea Thailand and Sri Lanka. However, in the Indian context, the figures speak wrongly as most of the doctors are concentrated in urban areas. The presence of untrained dais is another cause of concern in many countries. In India most of the trained doctors, nurses find green pastures in developed countries due to lack of opportunities in the country. Regarding utilization of health facilities China, South Korea and Sri Lanka dominate the list. A mere one third population utilise these facilities in India. Sanitation and safe water availability are better in China, South Korea, Sri Lanka, Thailand and Indonesia. However, India and Bangladesh lag behind very much in these parameters. How China, South Korea and Sri Lanka are progressing towards better quality of life? These countries successfully utilised the indigenous medical systems effectively. This is lacking both in India and Bangladesh. The factors responsible for dismal picture in these countries are illiteracy, less per capita daily intake of food, lower life expectancy, high infant mortality and low levels of communication technology i.e., Radio and Television. Though India and Bangladesh lag behind all the other Asian countries considered here, India can progress well if better

management strategies followed ensuring the participation of people at all levels.

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## 54. TEACHING SCHOOL CHILDREN ABOUT HEALTH: RADIO INSTRUCTION IN BOLIVIA

Many personal habits and life-style choices that have important consequences for health are formed early in life. Health education in schools can help young people make informed choices and so reinforce the effect of schooling on health.

Bolivia has had success with health education through radio lessons. Radio instruction was first introduced in 1987 for teaching mathematics and proved to be both inexpensive (with costs per pupil averaging less than \$1 a year) and effective. In 1989 the health and education ministries began to try out the use of radio for teaching disease prevention to schoolchildren, starting with a module on diarrhea prevention and oral rehydration. Children ages 8-13 were targeted because they often take care of younger siblings and perform house hold chores involving food preparation and sanitation. They thus have a strong influence on their own health and that of younger siblings. The radio health program emphasizes actions that a child can do for himself or can do for or teach to a younger sibling. It rests on the belief that children who learn basic health concepts and practices at a young age are more likely to maintain them as parents.

It is still too early to assess the long-term health impact of teaching health lessons through radio. Nonetheless, pupils already show significant gains in several areas, including ability to recognize symptoms of dehydration and knowledge of the proper mixture and application of homemade oral rehydration solution. There is also evidence of increased hand-washing, and more households are using simple water filters.

The radio program is now being expanded. In 1993 more than 1,000 third- and fourth-grade classrooms will receive broadcasts of a new curriculum that includes lessons on cholera, personal and dental hygiene, acute respiratory infections, immunizations, infectious diseases, and accident prevention. Nutrition, environmental health, and self-esteem are to be added in 1994. In response to parents' requests, a complementary community-based radio program is also being developed and tested.

*Source: WORLD DEVELOPMENT REPORT, 1993.*

## 55. SEX EDUCATION IN SCHOOLS TO PREVENT AIDS

The results of a survey carried out by the world Health Organization Global Programme on AIDS (WHOGPA) reveal that there is no evidence that sex education in schools leads to earlier or increased sexual activity in young people.

The findings, in a new report released on world AIDS Day (1 December 1993), show that in 35 studies considered:

- Sex education increased the adoption of safer practices in sexually active youth (ten studies);
- Sex education led either to a delay in starting sexual activity or to a decrease in overall sexual activity (six studies);
- Access to counselling and contraceptive service did not encourage earlier or increased sexual activity (two studies);
- The other 17 studies shown neither an increase nor decrease in the levels of sexual activity.

The most recent study reviewed, sampled 1800 teenage boys in the United States aged between 15-19 years in 1992. It found that the majority of them had received formal instruction on AIDS, birth control, and resisting pressure for sexual intercourse. This was associated with a decreased number of sexual partners, frequency of intercourse and increased condom use.

The findings are considered particularly important because, based on currently available data, the WHO GPA estimates that at least half of all HIV infections to date worldwide have occurred in youth between 15 and 24 years of age. More than one billion people — one fifth of the world's population — are in this age range.

“Infections among young people are driving this epidemic,” says Dr Michael Merson, Executive Director of the WHO GPA. “The belief that sex and AIDS education may encourage sexual activity in young people is a powerful barrier to the introduction of HIV prevention programmes for youth. Yet, all the evidence we have looked at suggests that the opposite is true. In fact, we believe that giving children and young people information about sexuality and the need for safe practices, helps them to protect themselves from HIV infection”.

The WHO advises that a range of options should be offered to young people, including postponing first sexual activity and, for those already

sexually active, not penetrative sex and the use of condoms for protected intercourse.

The survey indicates that sex education is most effective when given before a young person becomes sexually active. Also, those programmes which promoted both postponement of sex and protected sex were more effective than those which promoted abstinence alone.

"In many societies sex education for children and young adults is one of the most hotly debated and emotive issues facing educationists today. But it is time to stop arguing. If we care for our children and young people we must give them the knowledge and the skills they need to make responsible and healthy positive choices when it comes to sex and protecting themselves from the risk of HIV infection," says Dr Merson.

Young girls are especially vulnerable to HIV infection. Last year in the USA, AIDS cases in women were almost 10% higher than the year before. In 1992, for the first time more American women with AIDS were infected through heterosexual sex than through injecting drug use.

This is particularly disturbing when one considers, on average, the 10 year time lag between initial HIV infection and the onset of AIDS. The trend in AIDS cases seen today reveals a pattern of infection a decade ago. Today, HIV infections in American women are likely to be much more common than the AIDS data indicate, and far more commonly due to sex.

In the developing world, the peak age of infection tends to be lower in girls than in boys. In a WHO analysis of reported data from Rwanda and Tanzania, young women under 25 accounted for 20% of female AIDS cases and young men for less than 9% of male cases. In sub-Saharan Africa, women becoming infected outnumber men by 6 to 5.

World wide, an estimated one million women will have become infected by HIV in 1993 alone. It is estimated that, by the end of the century, thirteen million women will have become infected with HIV and four million of them will have died.

"We could make a real difference and slow the spread of HIV if we learn to be open and frank with young people," says Dr Merson. "Those countries which are the most open about sexuality also tend to have the lowest birthrates and lower teenage pregnancies. And we know that pregnancy rates underestimate the number of occasions on which unsafe sex takes place. So clearly, the widespread introduction of well-planned sex education will go far to protect our children from the risk of HIV infection now."

*W.H.O. PRESS RELEASE NOV.1993.*



## 56. AIDS EDUCATION - THEORY AND PRACTICE

**Table A**

### Issue and Challenges in Planning and Implementation of “Community Programme and Activities for AIDS Prevention and Control in South East Asia”

Topic	Issues	Challenges
1. Access to high risk behaviour groups, e.g. prostitutes, clients of prostitutes, IVDUs and men who have sex with men.	<ol style="list-style-type: none"> <li>1. Difficult to identify and access.</li> <li>2. Family and social needs are not identified.</li> <li>3. Societal stigma against these groups</li> </ol>	<ol style="list-style-type: none"> <li>1. Policy changes.</li> <li>2. Improving access to these group.</li> <li>3. Changing the attitudes and values of health workers, police and other concerned citizens.</li> </ol>
2. Communicating on sexual themes.	<ol style="list-style-type: none"> <li>1. Isolating sex themes from other health and education topics.</li> <li>2. Demystifying sex.</li> <li>3. Reaching parents, teachers and health professions.</li> <li>4. Introducing sex education against socio-cultural barriers.</li> </ol>	Using effective communications with development of human resources and communication skills.
3. Skills and competence needed, especially communication skills.	<ol style="list-style-type: none"> <li>1. Lack of appropriate communication resources and skills for specific situations, e.g. for making street contacts.</li> <li>2. Dealing with HIV positives.</li> </ol>	Making health education and teaching for decision making and not for indoctrination.

*Table A Contd..*

Topic	Issues	Challenges
<p>4. Research and how to effect behaviour change.</p>	<ol style="list-style-type: none"> <li>1. A sensitive subject for research.</li> <li>2. Hypocrisy associated with attitudes stated and behaviour practised.</li> <li>3. In some pockes, polygamy and polyandry have social sanction.</li> </ol>	<ol style="list-style-type: none"> <li>1. Giving research high priority.</li> <li>2. Overcoming scarce resources for research.</li> <li>3. Dissemination and utilization of research findings.</li> </ol>
<p>5. Updating oneself on AIDS knowldge so as to effectively educate the community.</p>	<ol style="list-style-type: none"> <li>1. Low awareness of how HIV infection is spread; how to take care of the HIV infected person.</li> <li>2. Insufficient teaching/ learning materials to update knowldge of health workers.</li> <li>3. Those involved with AIDS programmes are not involved with AIDS education.</li> </ol>	<ol style="list-style-type: none"> <li>1. Deeply entrenched moral and social values.</li> <li>2. Raising women's status.</li> <li>3. Advocacy efforts directed at politicians, policymakers and opinionleaders.</li> </ol>

# Table B

## Meeting the Challenges

Group	Advocacy	Service levels	Management and staffing	Collaboration	Role of government and non-government agencies
1. High risk behaviour groups	Through; 1. Publicity campaigns to change political climate, meetings and panel discussions including involvement of high risk behaviour groups in advocacy programmes. 2. Curbing of laws that come down heavily on drug users, sex workers, gay people, etc.	1. HIV testing facilities. 2. Treatment facilities. 3. Condom distribution. 4. Disseminating information on available services. 5. Mobile vans comprehensively designed for blood testing counselling and health education.	1. Agency to coordinate activities with capability and authority including provision of office space. 2. Quality control of condoms. 3. Safe disposal of needles and syringes. 4. Provision of hardware and software resources including educational materials. 5. Staff to include health educators and social workers, media personnel, nurses and doctors, youth, students, women's groups, ex-IVDU and sex workers, and well-known public personalities.	Coordinating agency to collaborate with existing government and NGOS and allied social agencies including international groups.	To work together to put AIDS on the political agenda and all activities related to its prevention and control.
2. Youth and Schools.	For; 1. Establishment of national committee for schools of health education, nutrition, environment, health services and sanitation at provincial, district, sub-district and school levels. 2. Teacher training programmes. 3. Involvement of mass media, Boy Scouts. 4. Peer group approaches. 5. National youth committees consisting of health, social welfare and other concerned ministries. 6. Advisory professional body at national levels.	Establishment of counselling unit at each school.	Ministry of Youth Affairs, the National Committee, Community Groups and leaders, parent-teacher associations.	Ministry of Education, Social Welfare, Youth Affairs and Religious Affairs. Also with youth and women's organizations and other allied groups.	Policy formulation, financial support and supervision.



Group	Advocacy	Service levels	Management and staffing	Collaboration	Role of government and non-government agencies
3. Women	<ol style="list-style-type: none"> <li>1. For policy changes through involvement of women's groups, media, international organizations.</li> <li>2. For education, income generations and health programmes for women.</li> <li>3. For provision of social environments supportive to women's rights.</li> <li>4. For policy changes in legislation relating to women's rights.</li> <li>5. For mobilization of women's groups and other activist groups.</li> </ol>	<ol style="list-style-type: none"> <li>1. dissemination of information to reach all women.</li> <li>2. Research into women's and AIDS problems.</li> <li>3. empowering women with skills in decision making.</li> <li>4. Family planning services (condom).</li> <li>5. Counselling services.</li> <li>6. Making HIV testing services readily available.</li> <li>7. Facilities for caring for women with AIDS.</li> </ol>	<p>Adequate management and staff for</p> <ul style="list-style-type: none"> <li>- diagnostic services</li> <li>- care of AIDS patients</li> <li>- counselling</li> <li>- information</li> </ul>	<ol style="list-style-type: none"> <li>1. Establishment of a national consultative body to look into women's issues represented by government/NGOS women's group etc.</li> <li>2. Collaboration with universities for research and with women related international organizations.</li> <li>3. Collaboration in monitoring related to women and AIDS.</li> </ol>	<ol style="list-style-type: none"> <li>1. Government to provide technical information, materials, finance and training and to include NGOS on national AIDS committees.</li> <li>2. NGOS to provide services, especially counselling, to the network and to mobilize communities to advocate for policy change.</li> </ol>

*SOURCE AIDSED Newsletter 1/1992.*

## 57. NGO'S ROLE IN WOMEN CENTERED DEVELOPMENT.

The Centre for Development and Population Activities (CEDPA) started management training programmes for women to enhance women's career opportunities and to improve project implementation tailored to women's needs. Women are thus prepared for catalytic and life changing role. The network of operation of CEDPA span across India, Pakistan, Nepal, Bangladesh, Kenya, Egypt Mali and Senegal, managed by CEDPA training graduates.

In India PRERANA- a local NGO with several CEDPA alumni, started many projects to extend welfare activities for women through women managers. A forum was created for women to meet and discuss problems in seven villages which also provided health and development activities like adult education, handicrafts, knitting and sewing, healthy baby shows, screening for T.B., Cancer, diabetes, dental and eye clinics as well as religious meetings.

The above activities gradually created a demand for Family Planning services borne out of options for better life and opportunities. The motivation factor was so strong that through family planning extension services and regular follow-up a high rate of 98% pill users, 95% condom users and 91% IUD users could be attained. High quality of services could be demonstratable as evident from average parity for pills at 2.3; IUD at 2.5, condom at 2.6 and sterilization at 4.1.

Women centered development programme can make a difference and contribute significantly to secure a better living standards for large numbers.

*Source: POPULI- United Nations Population Fund Journal. Vol.17 No.3. Sept. 1990.*

## 58. TRADITIONAL MEDICAL PRACTITIONERS AND THE DELIVERY OF ESSENTIAL HEALTH SERVICES

Many simple health activities do not require extensive professional training or major facilities and equipment. Health workers based in clinics or in their own communities play an important role in delivering these services. The millions of community-based traditional health practitioners have enormous potential as public health workers and providers of essential clinical services if governments can give them the appropriate training, information, and incentives.

Thus far, the experience with modern-traditional collaboration has been mixed. A number of projects have failed because of poorly designed training and inadequate supervision, and many governments need to do more to curb unnecessary and dangerous practices by traditional healers. But there have also been instructive successes.

\* An evaluation of workers participating in a volunteer program for detection of malaria in northern Thailand found that the performance of volunteers who were traditional healers was superior to that of other volunteers. The program, which began in 1961, had by 1988 more than 40,000 malaria-control volunteers distributed across 34,000 Thai villages. Volunteers trained by the Ministry of Health are expected to examine villagers, take blood samples, prepare smears to be sent to the district malaria clinic for analysis, and treat fever. They also provide malaria-related education to the villagers. In comparison with alternatives such as paid outreach workers, the volunteers improve case detection and save the government considerable expense.

A WHO study found that traditional healer volunteers in Thailand were more active in pursuing and identifying malaria cases than other volunteers and that they tended to remain in the program longer because their service enhanced their standing in the community. Villagers indicated that they felt more confident about having someone they already knew as the village traditional healer draw their blood and administer treatment.

\* In western Kenya the African Medical and Research Foundation (AMREF) has trained male and female traditional health practitioners who live in remote villages to dispense drugs and some types of contraceptives. Since the project began, the share of women of reproductive age using modern contraception in six pilot sites has risen from less than 10 percent to more than 25 percent. The Kenyan government has asked AMREF to expand the project.



\* In Bangladesh a program to train and support midwives to work with traditional birth attendants helped to lower maternal mortality rates by 60 percent over a ten-year period. The results of the program indicate that, given adequate support systems, community based services could bring about a substantial decline in maternal mortality.

*Source: World development report, 1993*

## 59. TARGETING PUBLIC EXPENDITURE TO THE POOR

When public spending on health is not targeted to the poor- as often happens, according to numerous studies-no other source of funds is likely to compensate. Which targeting mechanisms work best in practice will depend on their impact on demand, their administrative costs, their technical and managerial requirements, and the level of political support. In countries where incomes are too low for a minimum essential package to be provided universally, there are four main mechanisms for targeting the essential package of services:

- \* Assess individuals seeking services on the basis of income, nutritional status, or other criteria and, depending on the assessment, provide services from the essential clinical package free of charge or according to a sliding scale of fees. In evaluating income, direct measurements or proxies (such as housing characteristics) can be used, but this tends to be more administratively costly than other mechanisms.
  - \* Subsidize essential clinical services for easily identified subgroups of the population (for example, all those living in certain low-income regions or neighborhoods or all children in public schools). Where social insurance mechanisms (usually financed through payroll taxes) exist, they generally tend to cover the relatively well-off. Targeting public finance to those not participating in social insurance will reach the poor, and administration will be relatively simple. In countries with established social insurance mechanisms, this targeting mechanism will often prove best.
  - \* Let individuals self-target. The essential services are available free of charge to all, but the program is designed in such a way as to deter the better-off from using them. Time costs, stigma, and fewer amenities associated with services of the mechanisms for encouraging self-targeting. Unfortunately, these same characteristics may discourage the poor as well as the better-off. Low-income working mothers, for example, may find that the time, for themselves and their children, involved in using subsidized services is an insurmountable obstacle.
  - \* Target by type of service. Offer free of charge, or subsidize heavily, services that are needed disproportionately by the poor. This sort of targeting mechanism is inherent in much of the essential package of clinical services. Prenatal and delivery services, management of the sick child, and STD and tuberculosis treatment are all services that if universally available, would especially benefit the poor.
- Source: WORLD DEVELOPMENT REPORT 1993





## *Part 4*

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### *Tables*



TABLE : 1

GOALS FOR HEALTH AND FAMILY WELFARE PROGRAMMES IN  
TERMS OF HEALTH FOR ALL BY 2000 A.D.

S.No.	Indicator	Goals			Present level in Tamil Nadu	
		1985	1990	2000		
1.	Infant Mortality Rate	R 122	-	-	R.65.0	(1991-SRS)
		U 60	-	-	U 41.0	(1991-SRS)
		T 106	87	below 60	T 57.0	(1991-SRS)
2.	Perinatal Mortality Rate	-	-	30-35	53.8	(1989-SRS)
3.	Crude Death Rate	12	10.4	9.0	8.8	(1991-SRS)
4.	Pre-School Child Mortality (1-5 years)	20.24	15.20	10	7.5	(1989-SRS)
5.	Maternal Mortality Rate	3-4	2-3	below 2	1.3	(1991-CRS)
6.	Life Expectancy at Birth	M 55.1	57.6	64	60.0	
		F 54.3	57.1	64	59.0	
7.	Babies with birth weight below 2500 gm (%)	25	18	10	22.0	
8.	Crude Birth Rate	31	27.0	21.0	20.8	(1991 - SRS)
9.	Effective couple Protection Rate	37.0	42.0	60.0	57.3	
10.	Net Reproduction Rate	1.34	1.17	1.00	1.33	
11.	Growth Rate	1.90	1.66	1.20	1.50	
12.	Family Size	3.8		2.3	4.5	
13.	Pregnant mother receiving antenatal care (%)	50-60	60-75	100	75	
14.	Deliveries by trained birth attendants (%)	50	80	100	68	(1989-SRS)
15.	Imm. Status (% Coverage)	TT (pregnant women)	60 100	100	95	
		TT (school children)				
		10 years	40	100	100	95
		16 years	60	100	100	66
		DPT (children below 3 yrs.)	70	85	85	100
		POLIO (infants)	50	70	85	100
		BCG (infants)	70	80	85	100
		DT (new school entrants)	80	85	85	100



TABLE : 2

## Population &amp; Economic Indicators Of India &amp; Few Other countries

COUNTRY	popu lation 1991 in millions	GNP PER capital in 1991 \$	% of popu lation under 15 yrs old 1990	women of child bearing age as % of all women 1991	Adult literacy rate 1990 M / F	% of population with access to		
						safe water supply 89-90 R/U	adequa sanitati 89-90 R/U	
Bangladesh	110.6	220	43	48	47 22	81 76	8 57	
Bhutan	1.5	180	na	47	51 25	30 60	7 50	
Burma (myanmar)	42	na	37	54	89 72	55 80	56 68	
India	866.5	330	37	50	62 34	85 87	2 53	
In donesia	181.3	610	36	52	84 62	51 72	33 51	
Korea	22	na	28	na	na na	na na	na	
Nepal	19.4	180	42	46	38 13	34 66	1 17	
SriLanka	17.2	500	32	54	93 84	55 80	56 68	
Thailand	57	1570	33	55	86 72	92 97	95 79	
U.K.	57.6	16550	19	48	na	na na	na	
Sweden	8.6	25110	17	47	na na	na na	na	
Japan	124.0	26930	18	50	99 99	na na	na	

na – not available

TABLE : 3

### Comparison Of Birth Rates And Population Growth Rates In Certain Countries

COUNTRY	CRUDE BIRTH RATE PER 1000 POPLN. 1991.	TOTAL FERTI LITY RATE 1991	TOTAL LIVE BIRTHS PER YEAR IN LAKHS, - 1991-	AVERAGE ANNUAL GROWTH OF POPLN % 1980-91.	ASSUM ED YEAR OF REACH ING NRR-1	%OF INFANTS WIHT LOW BIRTH WEIGHTS 1990.	LIFE EXPECT ANCY AT BIRTH IN YEARS 1991
Bangladesh	34	4.4	45.1	2..2	2015	50	51
Bhutan	39	5.9	63	2.1	2035	na	48
Burma (Mynamar)	33	4.3	14.11	2.1	na	16	61
India	30	3.9	256.5	2.1	2015	33	60
Indonesia	25	3.0	51.04	1.8	2005	14	60
Korea	24	2.4	5.33	1.8	na	na	70
Nepal	38	5.5	7.8	2.6	2030	na	53
Srilanka	21	2.5	3.7	1.4	2000	25	71
Thailand	21	2.3	11.7	1.4	1995	13	69
U.K.	14	1.9	7.92	0.2	2030	7	75
Sweden	14	2.0	11.7	0.3	1995	5	78
Japan	10	1.5	13.8	0.5	2030	5	79

na – not available

TABLE : 4

## COMPARISON OF DEATH RATES IN CERTAIN COUNTRIES

COUNTRY	crude death rate per1000 popln. 1991	infant mortality rate per 1000 live births 1991	peri natal morta lity rate 1990	under five morta lity rate 1991	mater nal morta lity per 100,000 live births 1988	median age at death 1990
Bangladesh	13	103	75	133	600	12
Bhutan	17	132	na	205	1305	na
Burma (Mynamar)	12	85	50	117	na	41
India	10	90	64	126	na	37
Indonesia	9	74	40	86	450	47
Korea	5	25	20	34	na	71
Nepal	13	101	90	147	833	12
Srilanka	6	18	19	21	80	73
Thailand	6	27	25	33	37	71
U. K.	11	7	na	9	na	77
Sweden	11	5	na	5	na	78
Japan	7	5	6	6	na	78

na – not available



TABLE - 5

## FACTORS INFLUENCING THE SITUATION OF CHILDREN IN ASIAN COUNTRIES.

FACTORS		DEVELOPMENT CONTEXT				CHILD VIABILITY			CHILD DEVELOPMENT				CHILD CARE									
DEMOGRAPHY		Economic production	Economic Distribu- tion	Public Expenditure	Consumption	Mortality/ Life Expectancy			Nutrition				Morbidity		Educational Status	Employment		Mother's status		Health services	Educational Services	
COUNTRY	INDICATORS	GNP per-capita	% Pop. below poverty line	Health expenditure per- capita	Energy consumption per capita	Life expectancy female/male	Infant mortality rate	Neonatal mortality rate	Rice production per- capita	Under 5 Yr. 2/3 degree malnutrition.	Mother breastfeeding at 3/6/12 months.	Low-birth weight	Incidence of IDD	Incidence of Malaria	Enrolment in Primary school (ratio)	Unemployment	Child labour (under 14 Yrs.)	Literacy rate female/ male	Female Pop. 15-44 Yrs.	Female labour force	Water supply urban/ rural.	Girls enrolment in Primary school.
		(US\$)		(US\$)	kg calories	Yr	1000 LB	1000 LB	1000 LB	KG	%	%	%	(000)	(000)	%	%	%	%	000	%	%
1. Bangladesh	101147	3811	36	1.3	62.5	48/49	124	85	233	63/21	98/97/89	50	3582	30.3	60	2.5	12.5	22/43	20317	8	39/47	50
2. Bahrain	1423	47	•	1.3	3	46/48	134	19	52	33/6	"	•	100	124.4	25	•	•	•	299	•	40/14	17
3. Barma	37690	1158	40	2	108	54/51	45	32	395	46/2	90/90/90	16	320	90.5	81	4.8	•	70/86	8370	31	36/21	48
4. India	749833	20326	37	0.9	292	57/57	105	67	181	33/5	•	30	9600	1875	92	•	5.5	29/57	163461	126	31	69
5. Indonesia	163876	4211	•	3	318	56/53	96	21	237	27/3	98/97/83	14	1840	147.5	121	2	8.6	65/83	57147	36	60/32	116
6. Korea	40467	882	9.8	10.6	1805	72/65	33	•	191	16	84.3	9	•	•	96	3.4	•	88/96	80025	39	67	96
7. Mongolia	1908	63	•	16	1909	65/61	49	•	322	•	•	10	•	•	105	•	•	90/96	416	•	•	106
8. Nepal	16534	596	40	1.7	25	46/48	134	44	201	50/7	99/99/97	27	1100	69	76	•	14.2	12/34	3314	39	71/11	47
9. Sri Lanka	16117	414	•	4.3	202	72/68	30	15	166	27/1	83/74/48	27	680	164	90	17.9	•	84/91	3856	35.9	76/26	101
10. Thailand	51705	1395	20	8.5	498	65/61	44	4	381	35/1	83/79/68	12	6.5	305	93	2.6	6.2	88/94	12342	43.4	61	97
11. Maldives	33	•	•	8.1	•	50/53	68	38	181	14/1	•	20	•	0.01	64	•	•	82	•	•	13/5	•

\* Data not available

Source: \* 1988 Asian and Pacific ATLAS OF CHILDREN IN NATIONAL DEVELOPMENT™,

## 6. MEASURES OF FERTILITY

TABLE : 6-1

Crude birth rates  
India and major States, 1989

India/States	Total	Rural	Urban
INDIA	30.6	32.2	25.2
Andhra Pradesh	25.9	26.3	24.4
Assam	29.4	30.0	21.7
Bihar	34.3	35.1	27.6
Gujarat	28.7	29.6	26.6
Haryana	35.2	36.6	30.1
Himachal Pradesh	27.7	28.3	20.4
Jammu & Kashmir	30.1	31.8	23.3
Karnataka	28.0	29.1	25.1
Kerala	20.3	20.2	20.5
Madhya Pradesh	35.5	36.7	30.3
Maharashtra	28.5	30.6	24.6
Orissa	30.5	31.1	25.0
Punjab	28.3	28.7	27.5
Rajasthan	34.2	35.4	28.8
Tamil Nadu	23.1	23.5	22.4
Uttar Pradesh	37.0	38.8	29.2
West Bengal	27.2	30.7	18.4

TABLE : 6-2

General fertility rates;  
India and Major States-1989

India/States	Total	Rural	Urban
INDIA	126.5	135.70	97.6
Andhra Pradesh	104.8	108.2	093.0
Assam	114.8	118.8	071.4
Bihar	157.2	161.6	119.2
Gujarat	123.4	132.8	103.9
Haryana	151.3	160.8	120.8
Himachal Pradesh	110.7	113.0	080.8
Jammu & Kashmir	104.0	107.9	087.6
Karnataka	111.9	118.1	096.0
Kerala	071.4	072.7	066.4
Madhya Pradesh	152.8	163.3	115.3
Maharashtra	111.6	118.1	099.2
Orissa	119.2	121.8	095.6
Punjab	114.8	117.9	107.0
Rajasthan	151.5	159.2	119.4
Tamil Nadu	086.7	089.5	081.4
Uttar Pradesh	161.6	174.9	112.4
West Bengal	109.5	125.1	071.5

General fertility rate (GFR) is the number of births per 1000 women in the reproductive age group (15 - 49 years)



**TABLE : 6-3**

The states can be grouped as under on the basis of the GFR for rural and urban areas combined:

Range	States
Below 100	Kerala, Tamil Nadu
100-125	Andhra Pradesh, Assam, Gujarat, Himachal Pradesh, Jammu & Kashmir, Karnataka, Maharashtra, Orissa, Punjab, West Bengal
125-150	—
150-175	Bihar, Haryana, Madhya Pradesh, Rajasthan, Uttar Pradesh

**TABLE : 6-4**

Age specific fertility rates, India  
and major States-, 1989

India/States	Age-group						
	15-19	20-24	25-29	30-34	35-39	40-44	45-49
INDIA	082.0	246.4	202.5	127.0	072.2	034.5	011.6
Andhra Pradesh	119.4	226.4	143.8	076.0	037.0	015.4	003.5
Assam	061.8	193.9	177.1	135.4	074.4	036.1	002.0
Bihar	104.4	247.4	250.6	189.0	130.2	066.4	027.4
Gujarat	039.4	273.6	215.5	116.1	049.6	018.6	005.0
Haryana	084.2	313.9	247.9	128.7	063.6	028.3	005.6
Himachal Pradesh	042.9	271.5	175.5	096.1	038.8	015.2	002.3
Jammu & Kashmir	040.9	179.6	198.2	124.5	080.2	036.9	007.7

*Continued.....*

India/States	Age-group						
	15-19	20-24	25-29	30-34	35-39	40-44	45-49
Karnataka	085.0	239.9	170.4	092.5	045.8	020.3	006.0
Kerala	027.0	164.8	130.4	054.9	018.8	007.3	001.9
Madhya Pradesh	125.5	297.7	230.3	145.0	083.9	038.9	010.5
Maharashtra	091.4	271.3	187.1	084.8	027.8	011.8	001.8
Orissa	069.5	232.2	214.5	119.2	056.3	023.1	006.5
Punjab	021.2	244.3	223.9	109.9	046.0	017.2	000.7
Rajasthan	096.5	282.8	244.0	159.7	093.1	040.8	019.8
Tamil Nadu	059.0	206.1	143.6	064.1	025.1	007.3	001.3
Uttar Pradesh	079.8	268.8	258.9	202.8	136.5	074.4	027.5
West Bengal	085.4	211.0	159.8	107.2	056.3	027.8	009.9

Total Fertility rate (TFR) indicates the average number of children expected to be born per woman during the entire span of her reproductive period if the age specific Fertility rates continue to be the same and there is no mortality.

**TABLE : 6-5** Based on the levels of TFR the states have been categorised as under:-

TFR	States
Below 2	—
2.0 - 3.0	Kerala, Tamil Nadu
3.0 - 4.0	Andhra Pradesh, Assam , Gujarat, Himachal Pradesh, Jammu & Kashmir, Karnataka, Maharashtra, Orissa, Punjab, and West Bengal,
4.0 - 5.0	Haryana, Madhya Pradesh, and Rajasthan.
5.0 - 6.0	Bihar and Uttar Pradesh.

**TABLE : 6-6**

Total fertility rates, India and major  
states, 1981-83 and 1987-89

India/states	1981-83	1987 - 1989	Percentage change w.r.t 1981-83
INDIA	4.5	4.0	-11.1
Andhra Pradesh	3.9	3.3	-14.5
Assam	4.2	3.7	-11.1
Bihar	5.6	5.3	-6.0
Gujarat	4.2	3.5	-15.9
Haryana	4.9	4.3	-12.2
Himachal Pradesh	4.0	3.5	-12.5
Jammu & Kashmir	4.5	3.9	-13.3
Karnataka	3.6	3.4	-6.5
Kerala	2.8	2.1	-26.2
Madhya Pradesh	5.2	4.7	-9.6
Maharashtra	3.7	3.5	-6.3
Orissa	4.4	3.7	-15.7
Punjab	4.0	3.4	-15.8
Rajasthan	5.5	4.7	-15.2
Tamil Nadu	3.3	2.5	-23.2
Uttar Pradesh	5.8	5.4	-7.5
West Bengal	4.1	3.5	-13.8



TABLE : 6-7

Gross reproduction rates by residence,  
India and Major States, 1989

India/States	Total	Rural	Urban
INDIA	1.9	2.0	1.4
Andhra Pradesh	1.5	1.6	1.3
Assam	1.7	1.7	0.9
Bihar	2.4	2.5	1.9
Gujarat	1.7	1.8	1.4
Haryana	2.0	2.2	1.5
Himachal Pradesh	1.6	1.6	1.1
Jammu & Kashmir	1.6	1.7	1.2
Karnataka	1.6	1.7	1.3
Kerala	1.0	1.0	0.9
Madhya Pradesh	2.2	2.4	1.6
Maharashtra	1.6	1.7	1.5
Orissa	1.8	1.8	1.3
Punjab	1.6	1.6	1.5
Rajasthan	2.1	2.2	1.7
Tamil Nadu	1.3	1.3	1.1
Uttar Pradesh	2.4	2.7	1.7
West Bengal	1.6	1.8	1.0

GRR indicates the average number of female children expected to be born per woman during the entire reproductive span of 15-49 years if there is no mortality among them, and they continue to have the same fertility rates as of now.

## 7. MEASURES OF MORTALITY

TABLE : 7-1

Estimated crude death rates by residence,  
India and major States - 1989

India/States	Total	Rural	Urban
INDIA	10.3	11.1	7.2
Andhra Pradesh	9.5	10.2	6.7
Assam	10.4	10.6	7.6
Bihar	12.1	12.5	7.9
Gujarat	9.7	10.0	8.9
Haryana	8.5	9.0	6.6
Himachal Pradesh	8.7	8.9	6.1
Jammu & Kashmir	7.6	7.9	6.4
Karnataka	8.8	9.6	6.5
Kerala	6.1	6.0	6.1
Madhya Pradesh	12.9	13.9	8.6
Maharashtra	8.0	8.9	6.3
Orissa	12.7	13.2	8.1
Punjab	8.2	8.7	6.8
Rajasthan	10.7	11.4	7.8
Tamil Nadu	8.7	9.7	6.8
Uttar Pradesh	12.6	13.7	8.2
West Bengal	18.8	9.5	7.7

TABLE : 7-2

Distribution of major states by rural and urban  
death rates, 1989

Rural death rate	Urban Death Rate		
	Below 7.0	7.0-9.0	9.0-11.0
Below 7.0	Kerala	—	—
7.0-9.0	Himachal Pradesh, Jammu & Kashmir, Maharashtra, Punjab	—	—
9.0-11.0	Andhra Pradesh, Haryana, Karnataka, Tamil Nadu	Assam Gujarat, West Bengal	—
11.0-13.0	—	Bihar, Rajasthan,	—
13 above	—	Madhya Pradesh, Orissa, Uttar Pradesh.	



**TABLE : 7-3**

Estimated death rates by sex and residence India-1989

Residence	Male	Female
Total	10.4	10.1
Rural	11.2	11.1
Urban	07.8	06.7

TABLE : 7-4

## INFANT MORTALITY RATE (SRS ESTIMATES) 1976 to 91.

State	YEAR															
	76	77	78	79	80	81	82	83	84	85	86	87	88	89	90	91
Andhra Pradesh	122	125	117	106	92	86	79	77	75	83	82	79	83	81	70	73
Assam	124	115	118	104	103	106	102	94	97	111	109	102	99	91	76	81
Bihar	-	-	-	-	-	118	112	99	96	105	99	102	97	91	75	69
Gujarat	146	138	122	123	113	116	111	106	106	98	107	97	90	86	72	69
Haryana	112	113	109	100	103	101	93	91	101	85	85	87	90	82	69	68
Himachal Pradesh	127	101	101	87	87	71	68	80	90	84	88	83	80	74	69	75
Jammu & Kashmir	68	62	73	76	72	72	68	71	75	86	81	73	71	69	70	-
Karnataka	89	83	82	83	71	69	65	71	74	71	74	75	74	80	70	77
Kerala	56	47	42	43	40	37	30	33	29	32	27	26	28	22	17	16
Madhya Pradesh	138	148	143	143	142	142	134	125	120	122	117	119	121	117	111	117
Maharashtra	83	108	81	86	75	79	70	79	76	68	63	66	68	59	58	60
Orissa	127	147	133	149	143	135	132	126	130	130	123	126	122	122	122	124
Punjab	108	105	117	92	89	81	75	80	66	71	67	62	62	67	61	53
Rajasthan	142	142	140	108	105	108	97	109	122	108	104	103	103	96	84	79
Tamil Nadu	110	103	105	100	93	91	83	87	78	80	80	76	74	68	59	57
Uttar Pradesh	178	168	177	162	159	150	147	155	154	140	132	126	124	118	99	97
West Bengal	-	-	-	-	-	91	86	84	82	77	71	72	69	77	63	71
INDIA	129	130	127	120	114	110	105	105	104	97	96	95	94	91	80	60

**TABLE : 7-5**

**Infant Mortality rate in 1991**

The goal of the National Health policy is to reduce the infant mortality rate (IMR) in the country to 60 or less per 1000 live births by 2000 AD. The IMR in 1991 was 80 and the interim goal for 1995 is to reach a level of 70 or less.

The infant mortality rate has declined from 129 in 1976 to 80 in 1991. While the decline in IMR during the ten year period from 1976 to 1985 was 25 points, in the last five years a decline of 24 points has been recorded.

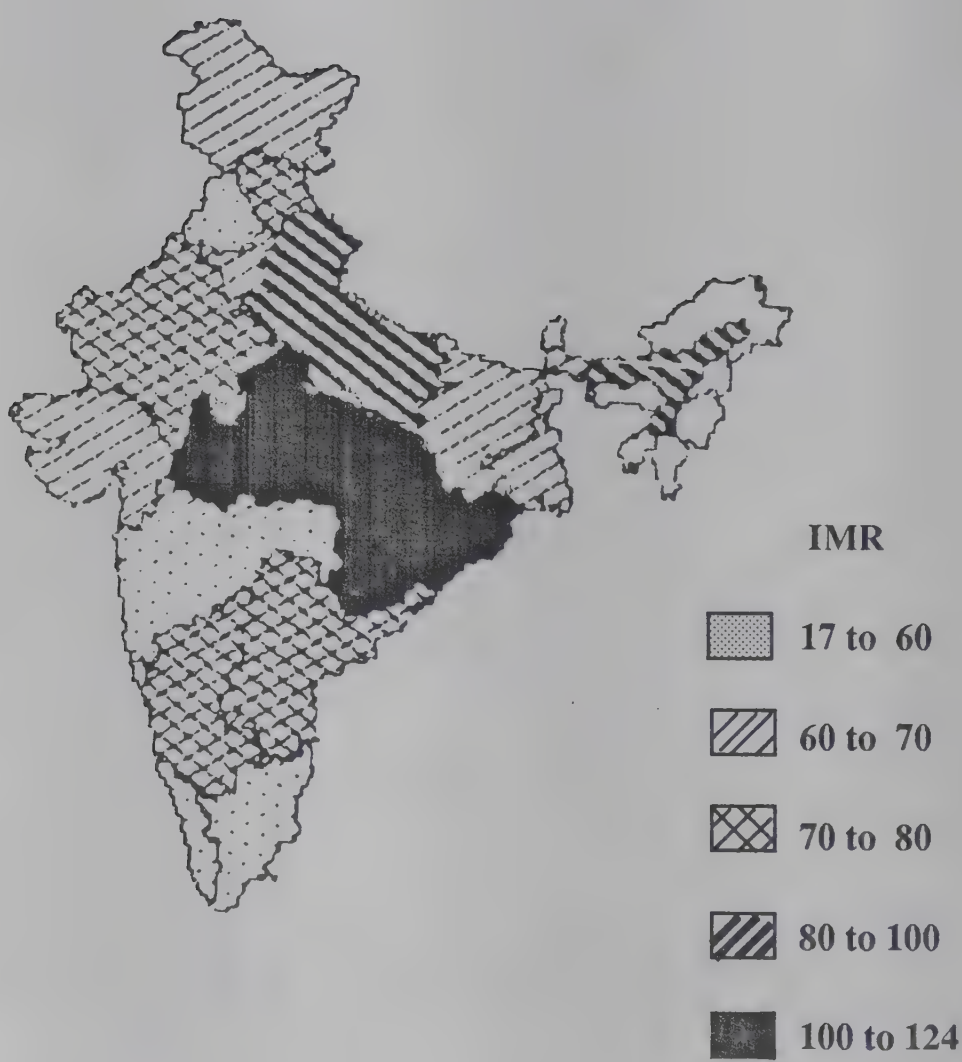




TABLE : 7-6

Estimated infant mortality rates by residence,  
India and major states, 1989

India/states	Rural	Urban	total
INDIA	98	58	91
Andhra Pradesh	88	53	81
Assam	93	63	91
Bihar	93	63	91
Gujarat	92	70	86
Haryana	88	58	82
Himachal Pradesh	78	33	75
Jammu & Kashmir	68	55	66
Karnataka	89	53	80
Kerala	23	15	21
Madhya Pradesh	125	78	117
Maharashtra	66	44	59
Orissa	125	78	121
Punjab	71	44	64
Rajasthan	103	58	96
Tamil Nadu	80	43	68
Uttar Pradesh	126	75	118
West Bengal	83	53	77

**TABLE: 7-7**

Infant mortality	States
Below 25	kerala
25 - 50	—
50 - 75	Jammu & Kashmir, Maharashtra, Punjab, Tamil Nadu
75 - 100	Andhra Pradesh, Assam, Bihar, Gujarat, Haryana, Himachal Pradesh, Karnataka, Rajasthan, West Bengal
100 - 125	Madhya Pradesh, Orissa, Uttar Pradesh

**TABLE : 7-8**

Estimated infant mortality rates by sex, India  
and major states, 1989

India/State	Male	Female
INDIA	92	90
Andhra Pradesh	89	73
Assam	97	85
Bihar	94	88
Gujarat	85	88
Haryana	75	90
Himachal Pradesh	59	92

*continued*

State	Male	Female
Jammu&Kashmir	72	60
Karnataka	86	74
Kerala	23	20
Madhya Pradesh	115	120
Maharashtra	64	53
Orrisa	123	119
Punjab	72	56
Rajasthan	95	99
Tamil Nadu	67	69
Uttar Pradesh	114	123
West Bengal	83	71

The states having higher male infant mortality rates as compared to female infant mortality rate are Andhra Pradesh, Assam, Bihar, Jammu & Kashmir, Karnataka, Kerala, Maharashtra, Orissa, Punjab and West Bengal.

**TABLE : 7-9**

Percentage of infant deaths to total deaths by residence,  
India and major states, 1989

India/States	Total	Rural	Urban
INDIA	27.1	28.4	20.1
Andhra Pradesh	22.1	22.6	19.1
Assam	25.7	26.1	18.2
Bihar	26.0	26.2	22.2
Gujarat	25.6	27.5	20.8
Haryana	34.0	35.6	26.3
Himachal Pradesh	23.9	24.6	11.0
Jammu&Kashmir	26.1	27.4	20.0
Karnataka	25.6	26.9	20.6
Kerala	7.2	7.6	5.0
Madhya Pradesh	32.2	32.9	27.5

*continued*



States	Total	Rural	Urban
Maharashtra	21.1	22.6	17.2
Orissa	29.1	29.4	23.9
Punjab	22.2	23.4	17.9
Rajasthan	30.7	32.1	21.6
Tamil Nadu	18.0	19.3	14.4
Uttar Pradesh	34.6	35.7	26.6
West Bengal	23.9	26.8	31.9

**TABLE : 7-10**

Percentage of infant deaths	States
Below 10	Kerala
10 - 15	—
15 - 20	Tamil Nadu
20 - 25	Andhra Pradesh, Himachal Pradesh, Maharashtra, Punjab, West Bengal
25 - 30	Assam, Bihar, Gujarat, Jammu and Kashmir, Karnataka, Orissa
30 and above	Haryana, Madhya Pradesh, Rajasthan, Uttar Pradesh

TABLE : 7-11

Neo-natal and post neo-natal mortality  
rates by residence, India-1989

Residence	neo-natal mortality	Post neo-natal mortality
Total	56.4	34.5
Rural	62.1	36.4
Urban	31.4	26.3

TABLE : 7-12

Neo-natal and post neo-natal mortality  
rates for major States- 1989

States	Neo-natal	Post neo-natal
Andhra Pradesh	54.8	26.2
Assam	62.3	28.7
Bihar	56.7	34.4
Gujarat	56.4	29.7
Haryana	49.7	32.5
Himachal Pradesh	38.7	36.6
Jammu & Kashmir	42.6	23.6
Karnataka	57.9	22.3
Kerala	14.2	7.2
Madhya Pradesh	67.0	50.3
Maharashtra	40.0	19.0
Orissa	75.5	45.5
Punjab	39.4	24.7
Rajasthan	60.6	35.7
Tamil Nadu	50.1	17.6
Uttar Pradesh	68.5	49.6
West Bengal	45.6	31.4

TABLE : 7-13

Neo-natal mortality rate	Post neo-natal mortality rate		
	Below 25	25-50	50-75
Below 25	Kerala	-	-
25-50	Jammu & Kashmir, Maharashtra, Punjab	Haryana, Himachal Pradesh,	-
50-75	Karnataka, Tamil Nadu	Andhra Pradesh, Bihar, Assam Gujarat, Rajasthan, Uttar Pradesh	Madhya Pradesh
75 & above	-	Orissa, West Bengal	-



TABLE 7-14

Percentages for neo-natal and post neo-natal  
deaths to total infant deaths: India  
and major States-1989

India/States	Neo-natal deaths	Post neo-natal deaths
INDIA	62.0	38.0
Andhra Pradesh	67.7	32.3
Assam	68.7	31.3
Bihar	62.2	37.8
Gujarat	65.5	34.5
Haryana	60.5	39.5
Himachal Pradesh	51.4	48.6
Jammu & kashmir	64.3	35.7
Karnataka	72.2	27.8
Kerala	66.7	33.3
Madhya Pradesh	57.1	42.9
Maharashtra	67.7	32.3
Orissa	62.4	37.6
Punjab	61.5	38.5
Rajasthan	62.9	37.1
Tamil Nadu	73.9	26.1
Uttar Pradesh	58.0	42.0
West Bengal	59.2	40.8

TABLE : 7-15

## Child Mortality Rates\* (1985 to 1989) SRS Estimates

States	1985	1986	1987	1988	1989
Andhra Pradesh	29.0	29.1	27.0	27.0	21.8
Assam	43.1	40.4	36.2	37.2	29.6
Bihar	48.5	43.3	40.0	38.0	32.8
Gujarat	37.3	37.4	33.3	30.9	29.2
Haryana	29.8	29.1	28.1	29.4	24.1
Himachal Pradesh	26.5	27.1	22.3	23.7	19.3
Jammu & Kashmir	30.4	29.0	20.1	25.0	19.6
Karnataka	24.7	24.5	25.1	24.1	25.7
Kerala	10.2	8.1	7.6	7.7	6.1
Madhya Pradesh	53.3	50.0	49.5	51.0	43.0
Maharashtra	23.3	20.6	21.1	22.3	18.0
Orissa	46.2	43.9	47.6	37.2	39.7
Punjab	26.3	24.1	20.4	21.4	21.9
Rajasthan	45.5	41.4	40.5	51.8	35.6
Tamil Nadu	25.6	25.1	23.2	21.4	20.6
Uttar Pradesh	54.0	54.3	52.0	46.7	41.3
West Bengal	27.3	25.6	24.3	22.4	21.9
India	38.4	36.6	35.2	33.3	29.9

\* No. of deaths of children in the 0-4 age group per one thousand population in the same age group.

**TABLE : 7-16**

Esstimated death rates for children aged 0 -4  
Years by residence and sex, India-1989

Residence	Male	Female	Person
Total	28.5	31.4	29.9
Rural	31.3	35.2	33.2
Urban	16.5	17.2	16.9

The goal by 2000AD is to reduce child mortality to 10 or less per 1000 persons.

The distribution of states according to rural and urban child mortality rates is as follows:

**TABLE : 7.17**

Child Moratality

Rural rates	Urban rates	
	Below 15	15-30
Below 15	Kerala	
15 - 30	Andhra pradesh, Maharashtra, Tamil Nadu, West Bengal	Haryana, Jammu & Kashmir, Panjab
30 - 45	-	Assam, Bihar, Gujarat, Rajasthan
45 and above		Madhya Pradesh, Orissa, Uttar Pradesh



**TABLE : 7-18**

Percentages of deaths among children aged 0 - 4  
years to total deaths by residence, India  
and major States- 1989

India/States	Total	Rural	Urban
INDIA	38.8	40.9	27.9
Andhra Pradesh	29.1	30.3	22.3
Assam	38.8	39.5	27.6
Bihar	42.1	42.6	34.0
Gujarat	34.9	37.8	27.4
Haryana	42.4	44.6	32.3
Himachal Pradesh	29.4	30.4	11.0
Jammu & Kashmir	35.8	37.9	25.9
Karnataka	35.6	37.8	26.7
Kerala	10.5	11.1	8.0
Madhya Pradesh	48.2	49.9	36.7
Maharashtra	30.3	32.0	25.9
Orissa	40.5	41.0	33.2
Punjab	30.9	32.1	27.0
Rajasthan	46.8	48.4	36.3
Tamil Nadu	25.0	27.0	19.4
Uttar Pradesh	47.2	48.7	37.0
West Bengal	32.7	36.4	20.1

TABLE 7-19

Estimated death rates for age - group 15-34  
years by residence, major states-1989

States	Total	Rural	Urban
Andhra Pradesh	2.9	3.2	2.0
Assam	3.2	3.4	1.4
Bihar	3.3	3.4	2.5
Gujarat	2.6	2.7	2.3
Haryana	2.0	2.2	1.2
Himachal Pradesh	1.9	2.0	1.7
Jammu & Kashmir	1.6	1.8	0.9
Karnataka	2.2	2.2	2.1
Kerala	1.3	1.3	1.0
Madhya Pradesh	2.1	2.2	1.9
Orissa	3.4	3.5	2.3
Punjab	2.6	2.8	2.1
Rajasthan	2.8	3.1	1.9
Tamil Nadu	2.5	2.9	1.7
Uttar Pradesh	2.7	2.9	2.1
West Bengal	2.4	2.6	1.8

**TABLE : 7-20**

Estimated death rates for age-group 35-49  
years by residence, major states-1989

States	Total	Rural	Urban
Andhra Pradesh	5.3	5.6	4.2
Assam	7.0	7.0	6.6
Bihar	6.7	6.8	5.6
Gujarat	4.8	5.2	4.0
Haryana	3.7	3.5	4.3
Himachal Pradesh	4.0	4.0	3.4
Jammu & Kashmir	5.0	4.7	6.1
Karnataka	4.9	5.0	4.6
Kerala	3.1	3.1	3.3
Madhya Pradesh	5.6	5.8	4.8
Maharashtra	4.4	4.5	4.2
Orissa	5.8	6.0	4.6
Punjab	3.9	4.4	2.7
Rajasthan	4.7	4.9	3.7
Tamil Nadu	5.0	5.1	5.0
Uttar Pradesh	5.7	5.9	4.8
West Bengal	4.6	5.3	3.2



TABLE : 8

Percentage distribution of deaths in India by cause related to child birth and pregnancy 1981-1986

Specific causes	1981	1982	1983	1984	1985	1986
Abortion	13.7	10.1	10.7	10.8	11.5	8.0
Toxemia	8.0	12.5	12.1	10.8	6.7	11.9
Anaemia	17.7	24.4	18.9	23.3	23.1	17.0
Bleeding of pregnancy and puerperium	23.4	26.2	23.5	18.8	15.9	21.6
Malposition of child leading to death of mother	9.2	7.2	8.3	6.2	7.7	6.2
Puerperium sepsis	13.1	8.3	11.6	10.8	13.9	13.1
Not classifiable	14.9	11.3	14.6	19.3	21.2	22.2
Total	100.0	100.0	100.0	100.0	100.0	100.0
percentage among total deaths	1.0	1.0	1.2	1.0	1.2	1.0

Source: Registrar General: Survey of causes of Death (Rural) 1984 and 1987.

**TABLE : 9**

**INDIA'S POPULATION AND MORTALITY RISKS BY AGE GROUP  
COMPARISON BETWEEN 1950, 1980 AND 1990**

AGE GROUP	POUPLATION (MILLIONS)			DEATH (MILLIONS)			MORATALITY RISK			LIFE EXPECTACY		
	1950	1980	1 990	1950	1980	1990	1950	1980	1990	1950	1980	1990
0-4	55	97	117	4.4	3.9	3.2	30.4	17.2	12.4	42	55	58
5-14	84	168	197	0.6	0.6	0.6	5.0	3.0	2.7	54	61	61
15-59	198	378	477	1.6	1.9	2.3	38.5	26.3	25.0	47	52	53
60-	20	42	59	1.5	2.7	3.3	61.1	51.2	48.9	14	15	16

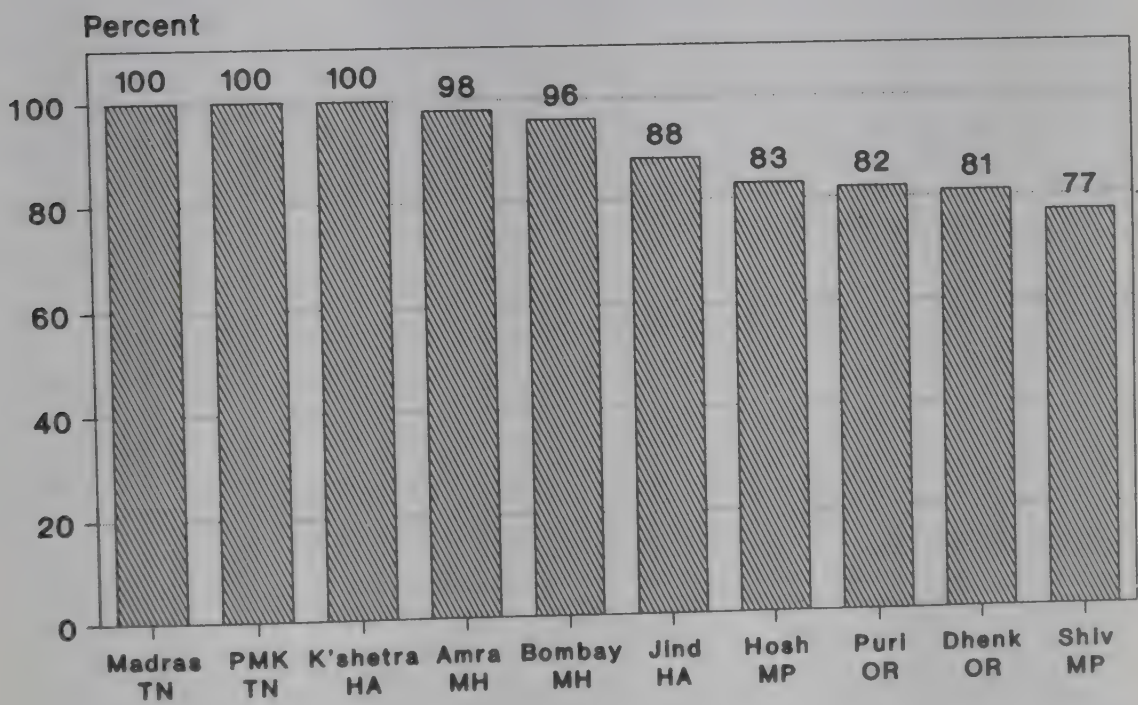
—SOURCE : WORLD DEVELOPMENT REPORT, 1993

TABLE : 10

UNIVERSAL IMMUNISATION PROGRAMME (U.I.P) OF INDIA reviewed by a Committee of international experts during August 1992. Their findings show good community response to aerial the UIP services.

1. ACCESS TO IMMUNIZATION SERVICES

Figure 1. India UIP Review: 10 districts  
Infants' access to immunization

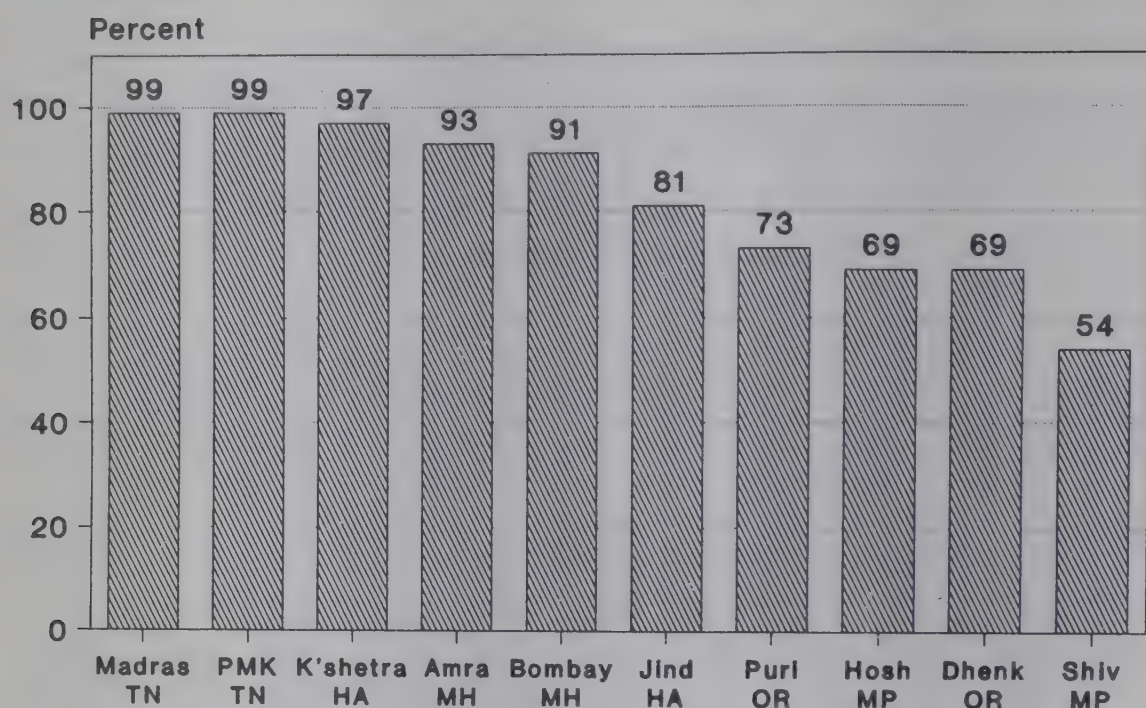


Accessibility is very important for any programme's success. The review was revealed a very high level of accessibility.



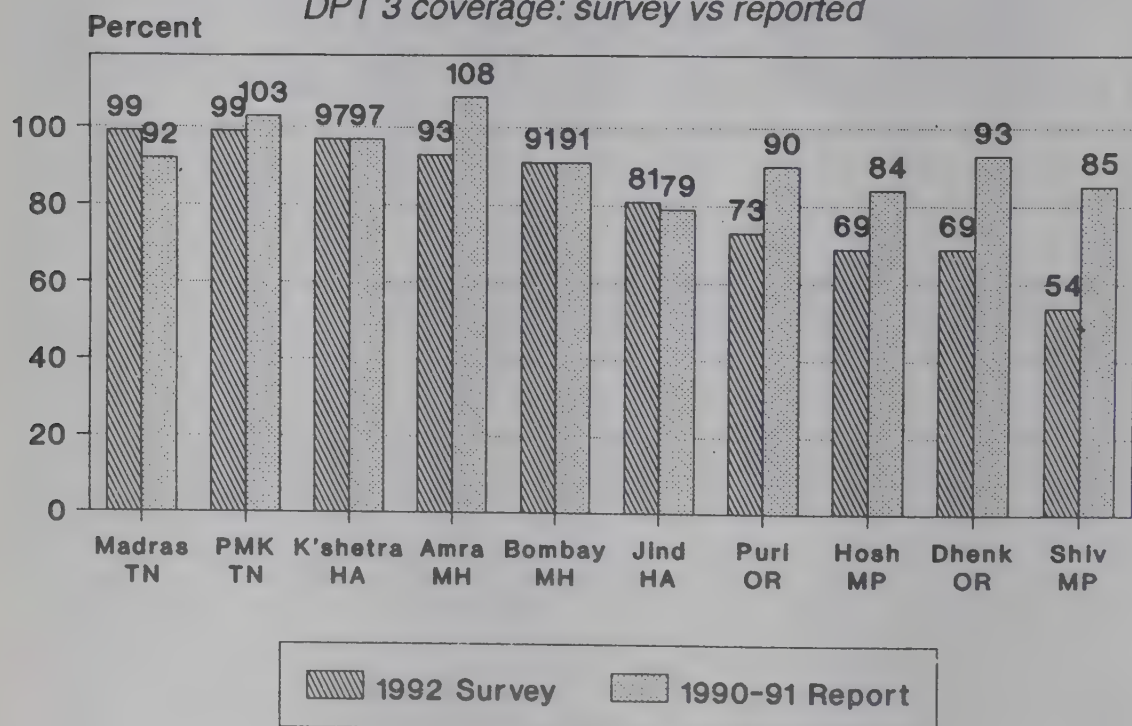
## 2. IMMUNIZATION COVERAGE

**Figure 2. India UIP review: 10 districts**  
OPV3 vaccination coverage



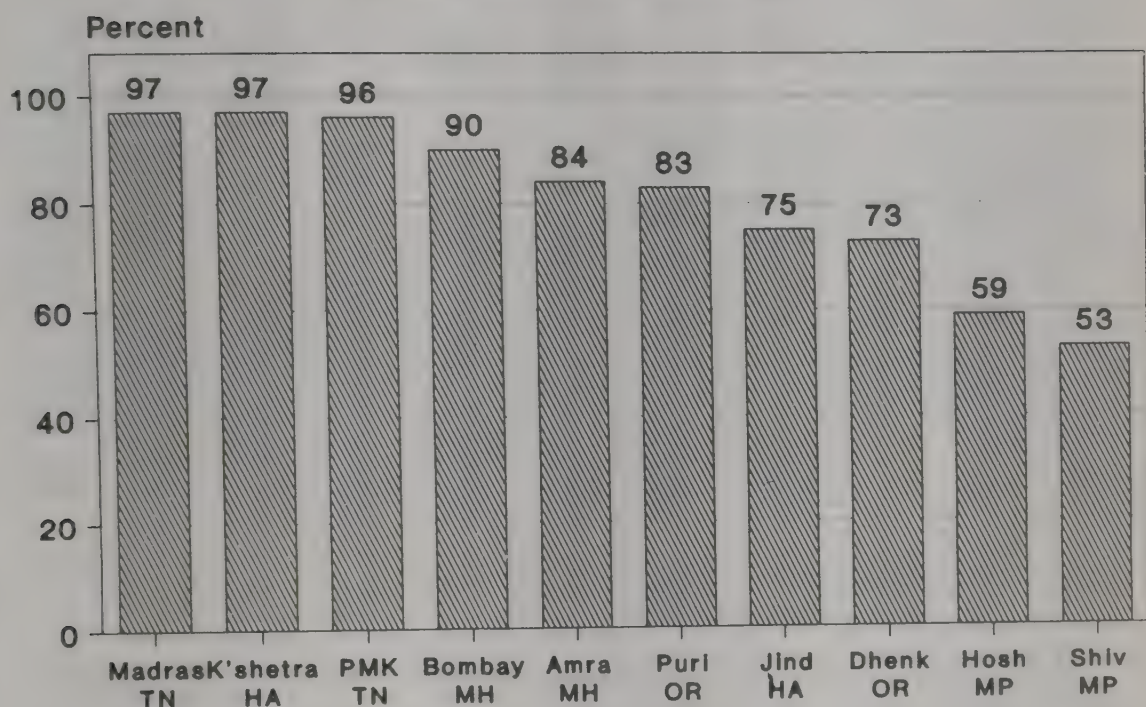
Coverage levels over 80% with the third dose of OPV in 6 out of 10 districts were recorded.

**Figure 3. India UIP review: 10 districts**  
DPT 3 coverage: survey vs reported

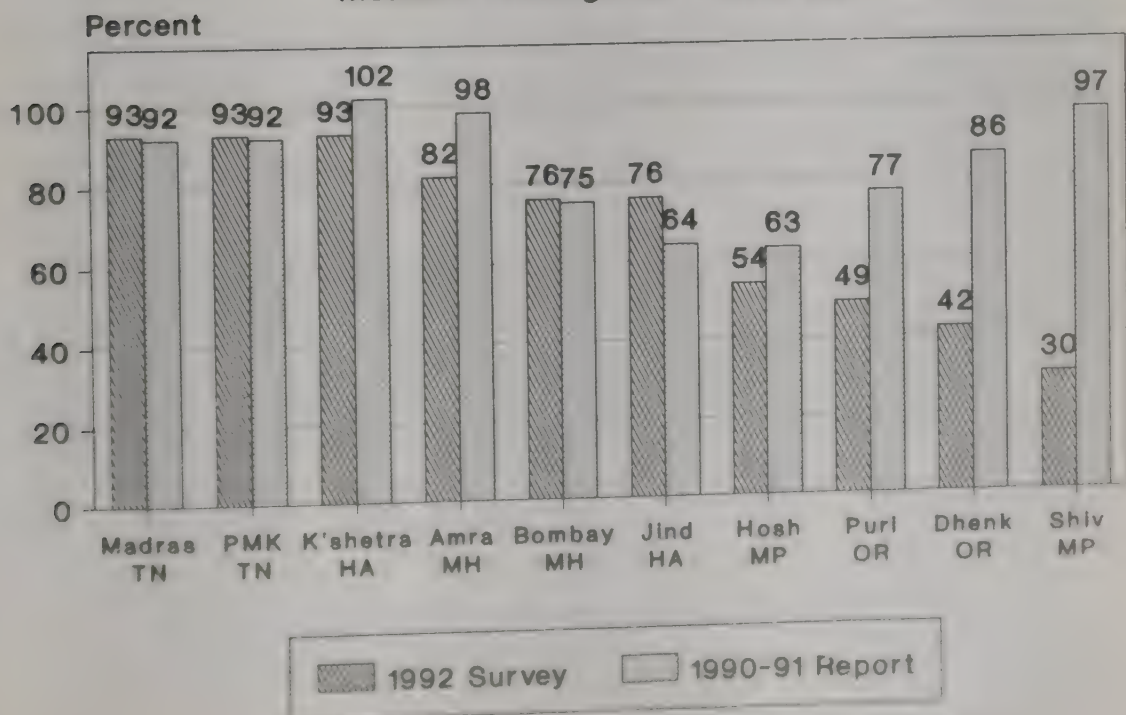


For districts with high coverage, the survey results and reported coverages are nearly similar.

**Figure 4. India UIP review: 10 districts**  
*TT2/B vaccination coverage*



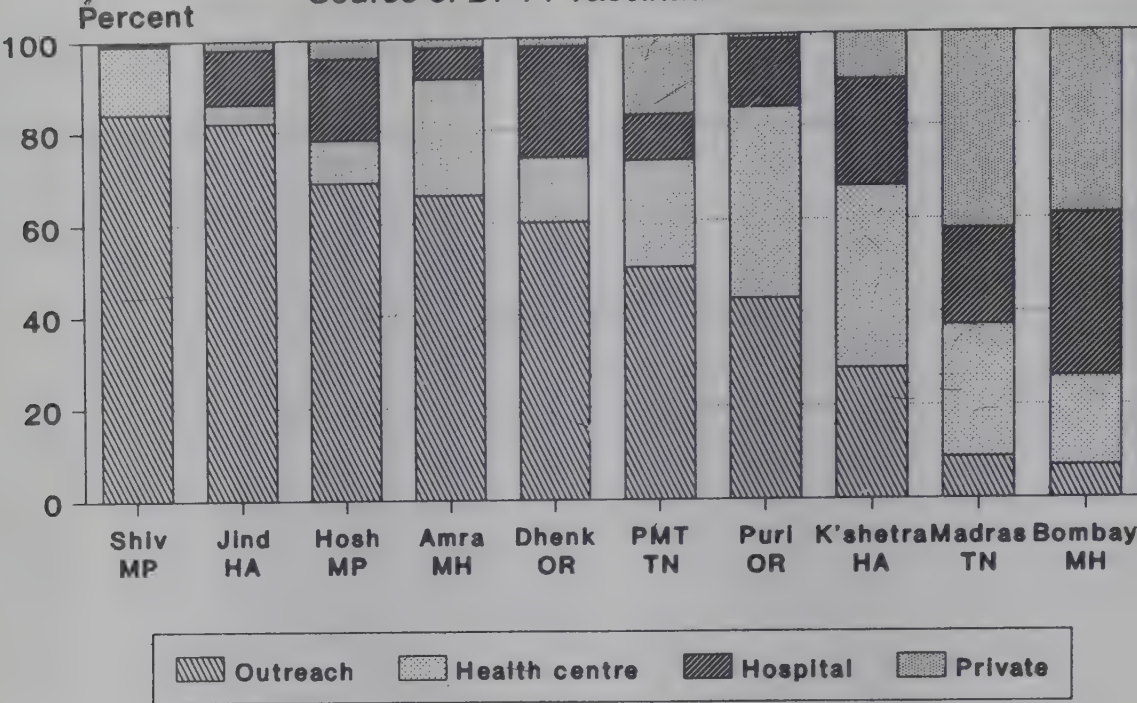
**Figure 5. India UIP review: 10 districts**  
*Measles coverage: survey vs reported*





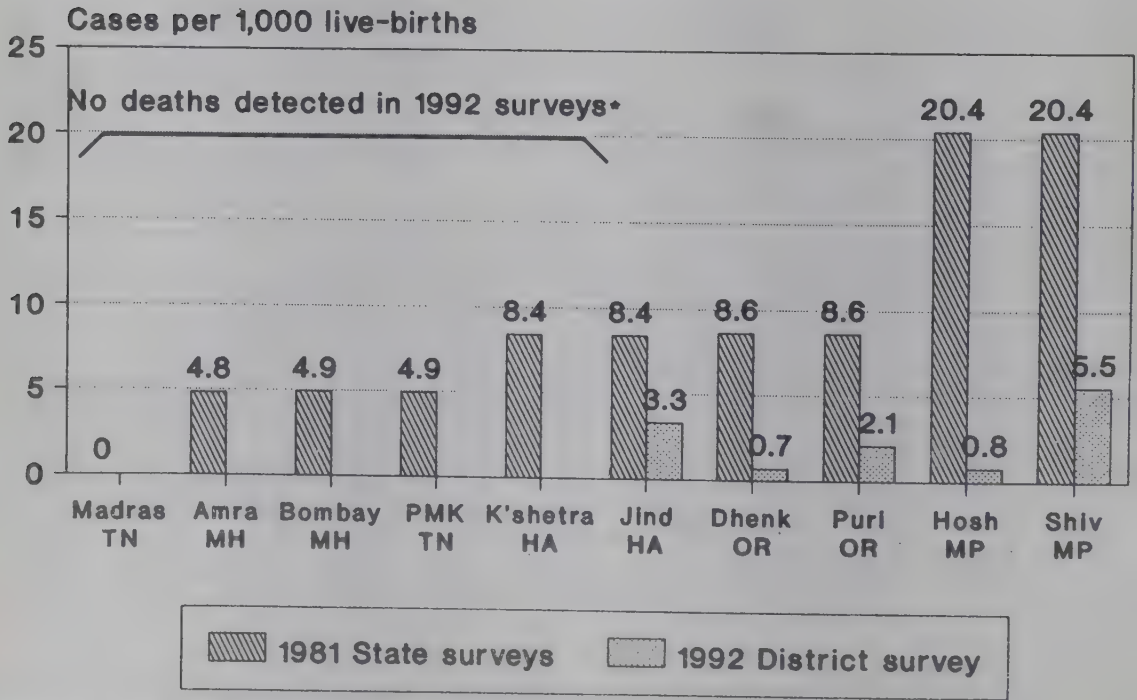
3. SOURCE OF VACCINATION

Figure 6. India UIP review: 10 districts  
Source of DPT1 vaccination



Government health staff play a major role in providing immunisation services. In major cities nearly 40% of services are through private sector.

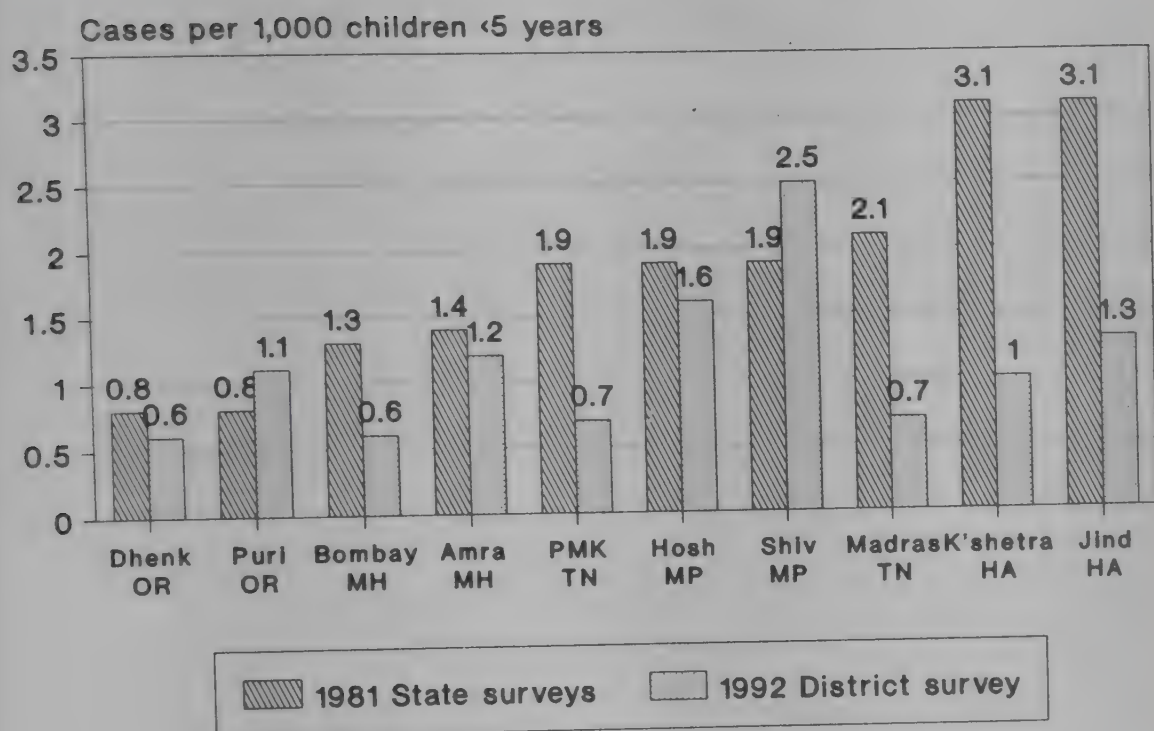
Figure 7. India UIP review: 10 districts  
Neonatal Tetanus incidence, 1981-1992



\*Sample size insufficient to detect NNT deaths with adequate confidence.



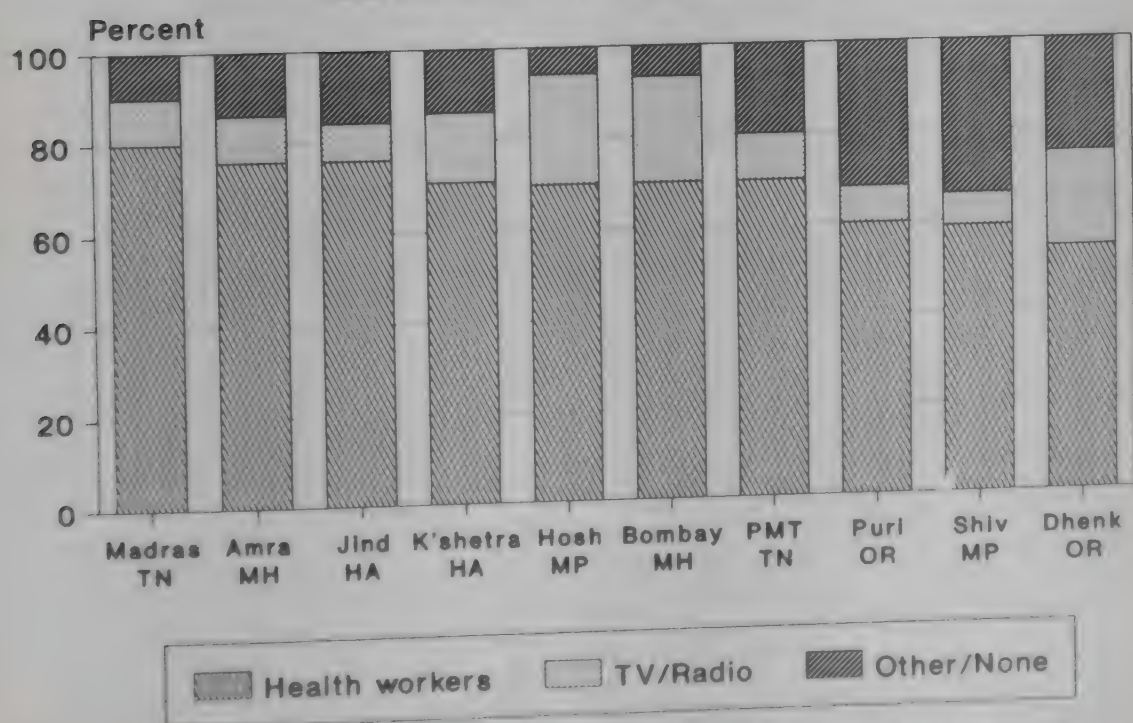
**Figure 8. India UIP review: 10 districts**  
*Poliomyelitis prevalence, 1981-92*



#### 4. COMMUNITY AWARENESS

Community awareness is crucial for the sustenance of UIP

**Figure 9 India UIP review: 10 districts**  
*Sources of community information*



Source of information about immunisation was mainly from health staff. There is scope for mass media (Press, T.V., RADIO) to play greater role.

**TABLE : 11**

Percent distribution of population by broad age groups for major states, India, 1989

India/States	Age - group		
	0-14	15-49	50 & above
INDIA	37.2	50.0	12.8
Andhra Pradesh	36.1	49.8	14.1
Assam	38.0	52.3	9.7
Bihar	42.1	46.4	11.5
Gujarat	35.6	53.2	11.2
Haryana	39.4	49.3	11.3
Himachal Pradesh	37.7	47.9	14.4
Jammu & Kashmir	37.5	50.8	11.7
Karnataka	36.4	50.8	12.8
Kerala	31.1	53.6	15.3
Madhya Pradesh	38.8	47.9	13.3
Maharashtra	35.3	50.7	14.0
Orissa	35.8	50.6	13.6
Punjab	33.9	51.7	14.4
Rajasthan	40.0	48.1	11.9
Tamil Nadu	31.9	53.2	14.9
Uttar Pradesh	39.7	48.0	12.3
West Bengal	35.3	52.8	11.9

**TABLE : 12**

Percent distribution of population by broad age-group by rural/urban, India, 1989

Residence	sex	age group		
		0-14	15-49	50 & above
Rural	Male	38.7	48.7	12.6
	Female	37.3	49.2	13.5
	Person	38.0	48.9	13.1
Urban	Male	33.9	54.6	11.5
	Female	34.7	52.8	12.5
	Person	34.3	53.7	12.0



TABLE : 13

Per cent distribution of birth by type of  
attention at birth in rural areas of  
major States, 1989

States	Type of attention at birth		
	Institutional	Attended by trained professionals	Attended by untrained professionals and others
Andhra Pradesh	16.8	22.8	60.4
Assam	11.6	08.8	79.6
Bihar	09.3	12.1	78.6
Gujarat	15.1	35.6	49.3
Haryana	16.2	65.3	18.5
Himachal Pradesh	16.5	19.5	64.0
Jammu & Kashmir	08.7	16.7	74.6
Karnataka	20.1	12.5	49.9
Kerala	84.3	06.4	09.3
Madhya Pradesh	04.1	12.0	83.9
Maharashtra	20.1	12.5	67.4
Orissa	04.8	13.9	81.3
Punjab	04.0	76.6	19.4
Rajasthan	01.9	14.2	83.9
Tamil Nadu	36.7	22.7	40.6
Uttar Pradesh	02.4	18.1	79.5
West Bengal	22.4	07.5	70.1

TABLE : 14

## BIRTH RATE IN TAMILNADU &amp; INDIA, 19971-1992.

TAMILNADU				INDIA		
YEAR	RURAL	URBAN	COMBINED	RURAL	URBAN	COMBINED
1971	32.9	27.8	31.4	38.9	30.1	36.9
1972	35.2	25.9	32.4	38.4	30.5	36.6
1973	32.2	24.9	30.0	35.9	28.9	34.6
1974	31.3	24.3	29.2	35.9	28.4	34.5
1975	32.7	25.9	30.7	36.7	28.5	35.2
1976	32.2	27.2	30.7	35.8	28.4	34.4
1977	30.7	27.5	29.8	34.3	27.8	33.0
1978	29.8	26.4	28.8	34.7	27.8	33.3
1979	29.7	27.2	28.9	35.1	27.6	33.7
1980	29.4	24.4	27.9	35.1	27.8	33.7
1981	29.7	23.9	28.0	35.6	27.0	33.9
1982	29.2	24.9	27.7	35.5	27.6	33.8
1983	29.0	25.9	27.9	35.3	28.3	33.7
1984	28.4	27.2	28.0	35.3	29.4	33.9
1985	25.2	23.8	24.7	34.3	28.1	32.9
1986	24.1	23.1	23.8	34.2	27.1	32.6
1987	24.1	23.7	24.0	33.7	27.4	32.2
1988	23.4	21.4	22.7	33.1	26.3	31.5
1989	23.5	22.4	23.1	32.2	25.2	30.6
1990	21.8	21.1	21.6	31.7	24.7	30.2
1991	20.8	20.8	20.8	30.9	24.3	29.5
1992	21.1	20.0	20.7	30.7	23.1	29.0
(Prov.)						

SOURCE: SAMPLE REGISTRATION SYSTEM, R.G. INDIA.

TABLE : 15

## DEATH RATE IN TAMILNADU AND INDIA, 1971-1992

TAMILNADU				INDIA		
YEAR	RURAL	URBAN	COMBINED	RURAL	URBAN	COMBINED
1971	16.5	9.3	14.4	16.4	9.7	14.9
1972	17.8	8.9	15.1	18.9	10.3	16.9
1973	16.5	8.4	14.1	17.0	9.6	15.5
1974	16.1	8.7	13.9	15.9	9.2	14.5
1975	17.5	9.0	15.0	17.3	10.2	15.9
1976	16.7	9.8	14.6	16.3	9.5	15.0
1977	15.2	10.1	13.7	16.0	9.4	14.7
1978	14.4	9.1	12.8	15.3	9.4	14.2
1979	13.4	8.8	12.1	14.1	8.1	13.0
1980	12.4	8.3	11.2	13.7	7.9	12.6
1981	13.5	7.9	11.8	13.7	7.8	12.5
1982	13.4	7.4	11.2	13.1	7.4	11.9
1983	13.4	8.5	11.7	13.1	7.9	11.9
1984	11.9	8.7	10.8	13.8	8.6	12.6
1985	10.9	6.9	9.5	13.0	7.8	11.8
1986	10.7	7.1	9.5	12.2	7.6	11.1
1987	11.1	7.6	9.9	12.0	7.4	10.9
1988	10.3	7.3	9.3	12.0	7.7	11.0
1989	9.7	6.8	8.7	11.1	7.2	10.3
1990	9.6	6.5	8.5	10.5	6.8	9.7
1991	9.5	7.6	8.8	10.6	7.1	9.8
1992	9.2	6.7	8.4	10.8	7.0	10.0
(Prov.)						

SAMPLE REGISTRATION SYSTEM, R. G. INDIA



TABLE: 16

INFANT MORTALITY RATE IN TAMIL NADU, AND INDIA, 1971-1992

TAMILNADU				INDIA		
YEAR	RURAL	URBAN	OMBINED	RURAL	URBAN	COMBINED
1971	127	77	113	138	82	129
1972	133	85	121	152	85	139
1973	122	67	108	143	89	134
1974	118	71	106	136	74	126
1975	129	65	112	151	84	140
1976	121	81	110	139	80	129
1977	114	79	103	140	81	130
1978	120	63	105	137	74	127
1979	114	63	100	130	72	120
1980	103	64	93	124	65	114
1981	104	55	91	119	63	110
1982	97	51	83	114	65	105
1983	101	59	88	114	65	105
1984	90	54	78	113	66	104
1985	95	53	81	107	59	97
1986	93	54	80	105	62	96
1987	86	54	76	104	61	95
1988	84	51	74	102	62	94
1989	80	43	68	98	58	91
1990	70	37	59	86	50	80
1991	65	42	57	87	53	80
1992	67	40	58	—	—	—

(Prov.)

SOURCE: SRS, INDIA

TABLE : 17

## TAMIL NADU - UNDER-5-DEATHS

YEAR	IMR	Neo-natal	Post natal	peri natal	SBR natal	o to 4yr	Neo %	post %	% of infant deaths to Total Deaths in State
1979	99.60	66.10	33.50	56.90	12.40	42.70	66.37	33.63	23.91
1980	92.70	60.80	31.90	53.20	11.40	38.70	65.59	34.41	23.09
1981	91.10	62.60	28.50	51.70	8.60	35.10	68.72	31.28	21.50
1982	82.50	54.90	27.60	44.10	6.50	31.60	66.55	33.45	20.33
1983	87.50	58.60	28.90	53.00	9.90	36.50	66.97	33.03	20.85
1984	78.30	56.30	22.00	50.20	7.80	27.40	71.90	28.10	20.24
1985	81.30	56.40	24.90	54.30	9.50	25.60	69.37	30.63	21.08
1986	79.80	57.10	22.70	55.40	10.40	25.10	71.55	28.45	20.03
1987	76.00	47.60	28.00	51.20	13.40	23.20	62.63	36.84	18.33
1988	74.00	52.40	21.30	56.20	15.60	21.40	70.81	28.78	18.03
1989	68.00	50.10	17.60	53.80	13.80	20.60	73.68	25.08	18.00
1990	59.00	—	—	—	—	—	—	—	—
1991	57.00	—	—	—	—	—	—	—	—

Column 1 to 9 : Source : SRS Year Book, Registrar General of India









